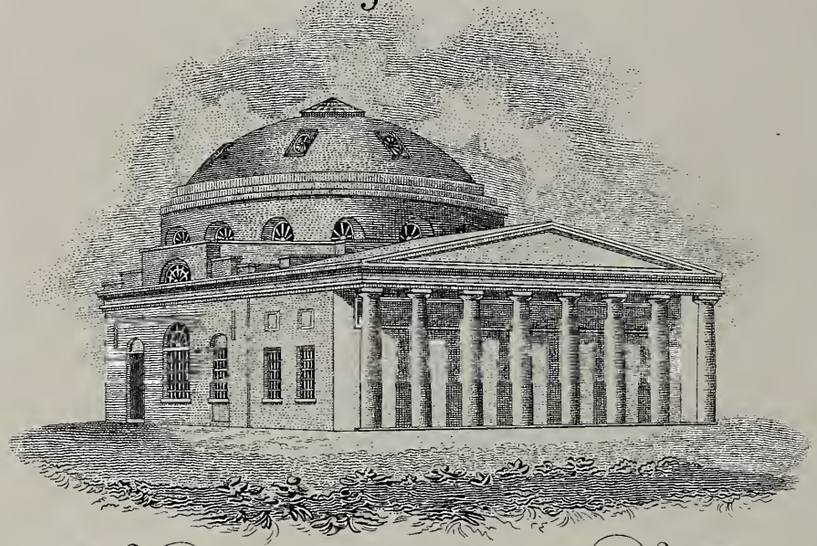
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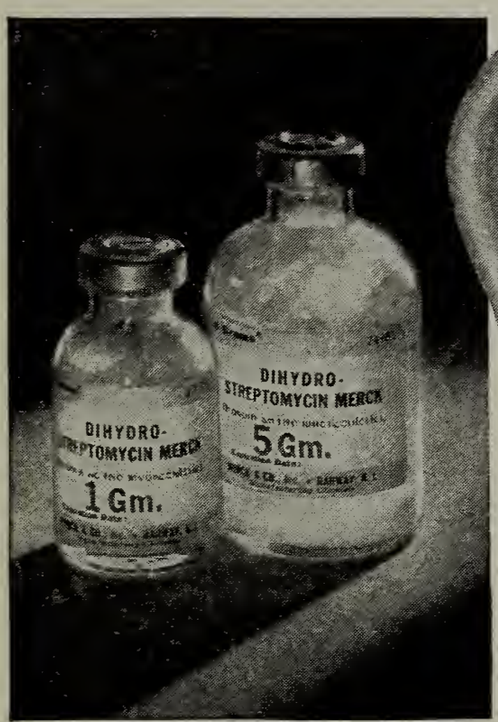
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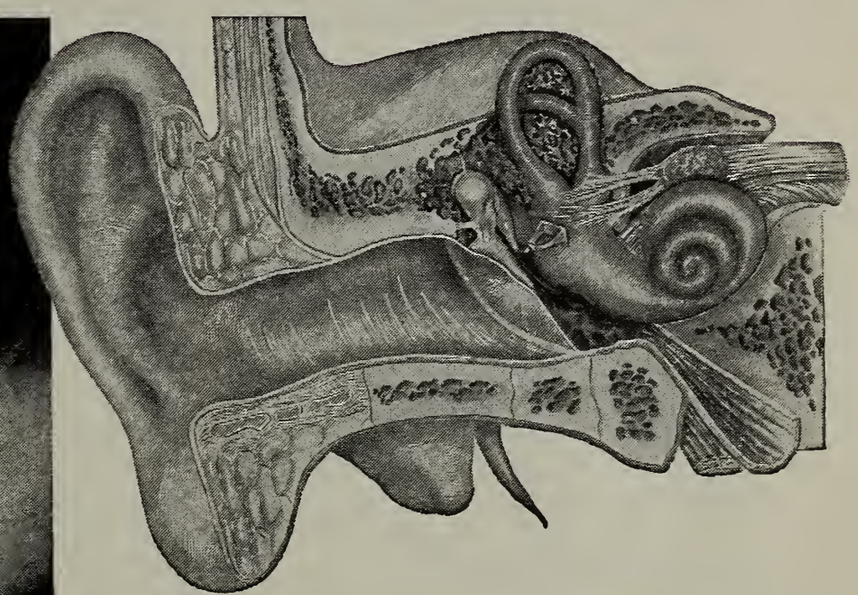
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Clinical Laboratory Methods and Diagnosis, in three volumes, by R. B. H. Gradwohl, M. D., ($40.00. Fourth Edition. *C. V. Mosby Company, St. Louis, Missouri)* is a depressing work for your reviewer for it dates him as well as buries him in a pile of laboratory instructions—all of which has grown from a small volume of a couple hundred pages into this encyclopedia. The index to the present work is much larger than Dr. Gradwohl's first book—and all of this has happened in my time.

In these three ponderous Tomes which are intended as works of reference on the shelves of the clinical laboratory of the country, will be found every item one could ever, at this time, have occasion to look up.—All done in a clear and readable style and well illustrated.

Organic Form and Related Biological Problems, by S. J. Holmes, ($5.00. *University of California Press, Berkeley, California)* deals with the ability of living creatures to effect their own construction and to keep it in a tolerable state of repair. The author hazards a mechanistic explanation for such apparently teleological behavior. If you are interested in the origin and nature of **Life,** you will enjoy this fascinating book.

Neurosurgical Pathology, by I. Mark Scheinker, M. D., ($8.75. *C. C. Thomas, Springfield, Illinois)* applies in a broad fashion a functional or dynamic concept to the subject. The author is our fellow member, Professor Scheinker of the University of Cincinnati College of Medicine. This approach serves to clarify the progressive nature of the clinical manifestations following central nervous system injury.

A Method of Anatomy, by J. C. Boileau Grant, ($7.00. Fourth Edition. *Williams & Wilkins Company, Baltimore, Maryland)* has been thoroughly revised and mostly rewritten. But the book adheres to its original method of teaching the student to think in anatomical relationships rather than to give him an immense number of facts to remember.

Husband Security, by Huldah Temple, ($2.00. *William-Frederick Press, New York City)* discusses the problem that American women face everyday—treated honestly with psychological understanding, in very human terms. No quack remedy or love potion is offered by this text but it does outline in detail a practical feminine program by which, the author says, in 99 cases out of 100, the wife will not lose her husband or face a broken home and a lonely old age.

Our national resources are dwindling while our population grows larger at an accelerated pace. In spite of what so many writers say, the home must be held together to give our future citizens a sense of security through a feeling of belonging. Loyal wives and mothers will lead the way and, if we men follow, most of our social problems will be solved.

The Clinical Application of Psychological Tests: Diagnostic Summaries and Case Studies, by Roy Schafer, M. A., ($6.75. *International Universities Press, Inc., New York City)* is monograph No. 6 in the Menninger Foundation Series. The work gives us a case collection which includes verbatim test records, interpretation of these, and sketches of the clinical picture in each case.

Bailey's Textbook in Histology, revised by Philip E. Smith and Wilfred M. Copenhaver, ($7.00. Twelfth Edition. *Williams & Wilkins Company, Baltimore, Maryland)* is still one of the outstanding texts for first-year medical students. It attempts at the same time to give functional significance to a microscopic structure as it is described.

A-B-C's of Sulfonamide and Antibiotic Therapy, by Perrin H. Long, M. D., ($3.50. *W. B. Saunders Company, Philadelphia)* is a handy pocket-sized manual of some 230 pages with concise, up-to-date information on the subject for the busy practitioner.

Occupational Marks and Other Physical Signs As a Guide to Personal Identification, by Francesco Ronchese, M. D., ($5.50. *Grune & Stratton, New York City).* If one has a knowledge of the stigmata of occupation, his reasoning in attempting to identify individual bodies and telltale causes of disease has been started in the right direction. The lesson that your reviewer got from reading this perfectly fascinating book was how poorly he had developed the faculty of correctly seeing what he looked at and how little he knew about the stigmata due to repeated occupational trauma, previous disease, and even hobbies. It is an important book for teaching physicians who are not too old how to look more closely at the skin of their patients.

Progress in Neurology and Psychiatry, Annual Review Volume III, edited by E. A. Spiegel, M. D., ($10.00. *Grune & Stratton, New York City)* condenses, abstracts, and reviews over 2800 papers. This type of publication in special fields where

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a large staff of men with extreme specialization try to condense for the men of broader interests what is going on in their field, should become more common.

Climate and Evolution, by William Diller Matthew, *(Special Publication of the New York Academy of Sciences, Volume I, page i-xii, 1-123)* is a reprint of the classical essay by Dr. Matthew first published in 1915. The author had made many annotations in his personal copy with the idea of bringing out a revision. These annotations have been included here. William King Gregory does a biographical sketch; a complete annotated bibliography of some 360 references is presented following the text and is the work of professors Charles Lewis Camp and Vertress Lawrence VanderHoof of the University of California. Dr. Matthews contributed much to the science of paleontology. He was one scientist who realized the value of his science for the philosophy and art of human living. All physicians interested in the effect of climate on animals including Man must have this reprint.

A.M.A.'s Intern's Manual, ($2.25. *W. B. Saunders Company, Philadelphia),* is much smaller in size but nevertheless contains twice as much information. It therefore comes more nearly doing what it is supposed to do.

Diagnostic Procedures for Virus and Rickettsial Diseases, ($1.00. *American Public Health Association, 1790 Broadway, New York City)* consists of 17 excellent chapters and a complete collection of laboratory methods at present applicable to the recognition of these diseases.

Rare Diseases and Some Debatable Subjects. by F. Parkes Weber, ($3.00. Second Revised Edition. *Staples Press, Inc., 70 East Forty-Fifth St., New York City)* deals with things that are really rare—a great number of dysplastic syndromes. All in all, a most interesting book—one which all who are intrigued by the curious and the rare will wish to own.

Frontier Doctor, by Samuel J. Crumbine, M.D., ($3.00. *Dorrance and Company, Philadelphia)* is the autobiography of a pioneer on the frontier of public health, and is also a record of the movement in preventive medicine and the efforts of the public to secure health for its ill in the early days of this century.

Correlative Neuroanatomy, by Drs. McDonald, Chusid, and Lange, ($3.00. Fourth Edition. *University Medical Publishers, Palo Alto, California)* again very nicely correlates injuries and diseases with the anatomy of the nervous system.

Interesting and Useful Medical Statistics, edited by William H. Kupper, M.D., ($6.50. *Wm. C. Brown Company, Dubuque, Iowa)* is a most valuable collection of hundreds of important statistical tables. It will be most useful to many physicians, teachers, writers, and research workers.

Pulmonary Tuberculosis and Its Treatment, by Hans Jacob Ustvedt, M.D., ($5.00. *Staples Press, Inc., 70 E. Forty-Fifth St., New York)* is a presentation of the modern views of pathology and therapy in Sweden with the emphasis on the practical.

Inter-Allied Conferences on War Medicine, 1942-1945, convened by the Royal Society of Medicine, ($10.00. *Staples Press, Inc. 70 East Forty-Fifth St., New York)* gives us the conclusions of 24 conferences exchanging the medical experiences in this field as well as the administration problems.

Technique of Treatment for the Cerebral Palsy Child, by Paula F. Egel, ($3.50. *C. V. Mosby Company, St. Louis, Missouri)* presents the work of Winthrop M. Phelps, by one who actually carries out the procedures as recommended.

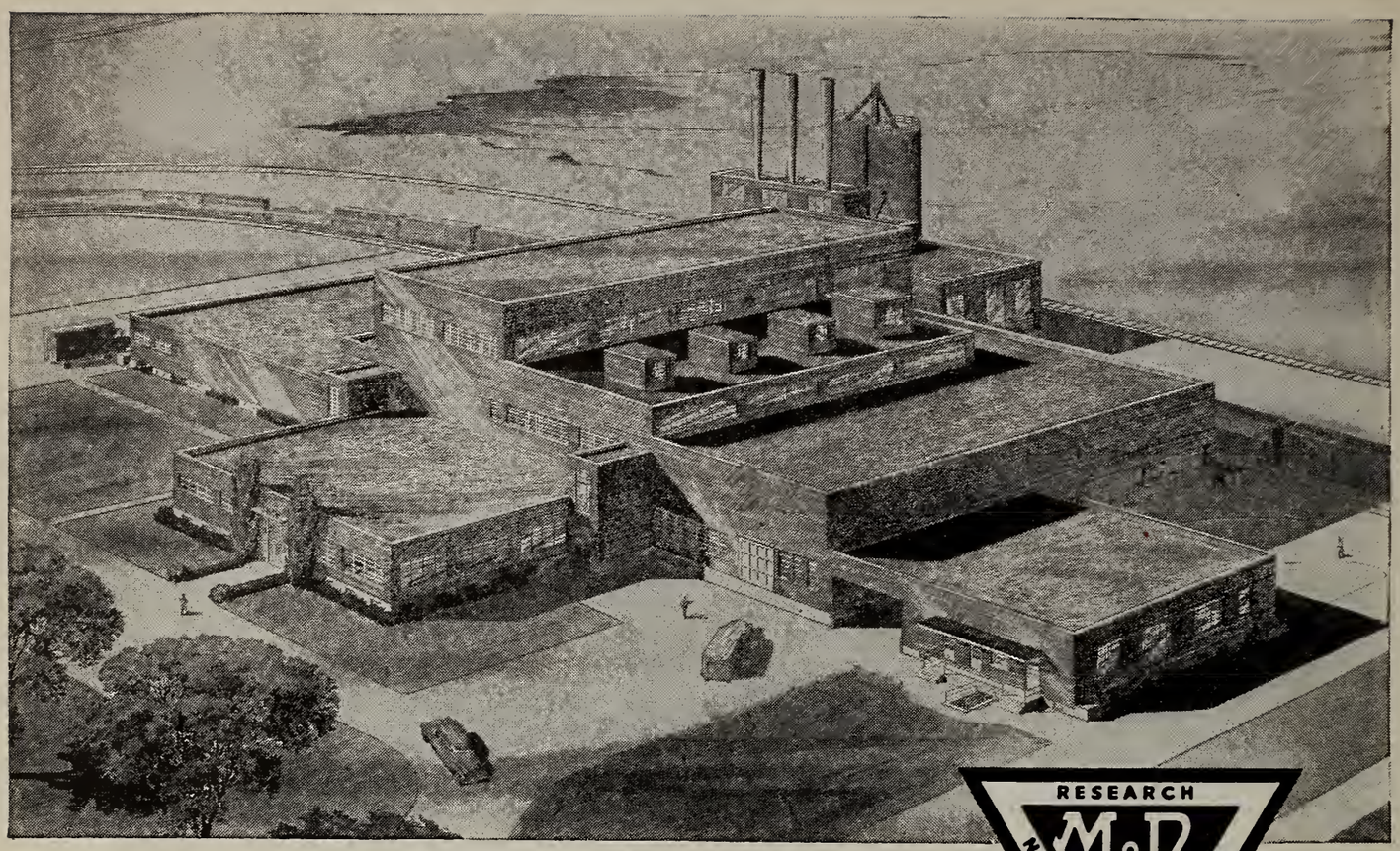
Portrait in Black—A Play in Three Acts, by Ivan Goff and Ben Roberts, (85 cents. *Samuel French, Inc., 25 W. Forty-Fifth St., New York)* is about a shopowner—a widow who is in love with a doctor who helped kill her husband and who is loved by a lawyer who manages her husband's estate.

Infant and Child in the Culture of Today, The Guidance of Development in Home and Nursery School, by Arnold Gesell, M.D., and Frances L. Ilg, M.D., ($4.00. *Harper and Bros., New York City)* is a practical book based on years of research in The Yale Clinic of Child Development.

Biology for Everyone, by W. Gordon Whaley, Ph.D., ($2.79. *Halcyon House, Garden City, New York)* has been designed by the Professor of Botany at the University of Texas, to meet a wide-spread demand for a readable work on the Science of Life.

British Surgical Practice, in eight volumes, ($15.00. Volume III. *C. V. Mosby Company, St. Louis, Missouri)* covers surgical problems from "Caesarian Section" to "Eyelids" in alphabetical sequence, part of the 60-odd sections written by a British master.

The Autobiography of Benjamin Rush, edited by George W. Corner, ($6.00. *Princeton University Press, Princeton, New Jersey)* is printed in full for the first time from the original manuscripts in possession of the American Philosophical Society. It includes his "Travels Through Life" as well as "Commonplace Books" for 1789-1813. This is a book with which every physician should be familiar.



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JONATHAN FORMAN, M. D., *Editor*

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An Outbreak of Newcastle Virus Disease in Tuscarawas County, Ohio

THOMAS F. McGOUGH, M. D., M. P. H.

ON September 19, 1948, chicken was served at the home of the X family. No other known contact was made with poultry during the several weeks prior to that date. The chicken which had been eaten was purchased locally, but had been shipped from out of state.

Three members of the family ate some of the chicken. The fourth member, an infant, did not partake.

On September 22, 1948, the six-year old child presented the following symptomatology: Sudden onset of nausea, vomiting, fever (101°), malaise, anorexia, abdominal pain, lumbar pain, and headache. Vomiting occurred three times and on September 22, 1948, only.

The patient was afebrile at the close of September 23, 1948, and on September 24, 1948, all of her symptoms had disappeared leaving a transient weakness but no evidence of paralysis.

On September 24, 1948, the second member (an adult) was seized abruptly with headache, nausea, vomiting, diarrhea, abdominal cramps, lumbar pain, and marked weakness. Temperature was 99°.

By September 26, 1948, this individual had recovered except for a persistent weakness which lasted for a week.

On September 26, 1948, chicken from the previously mentioned source was again served in the household.

On September 28, 1948, a third member (also an adult) of the family was seized in the late evening with abrupt headache, nausea, and diarrhea. This was quickly followed by generalized myalgia and weakness. Temperature reached 101°. Anorexia continued until September 30, 1948, and weakness until October 3, 1948. All other symptomatology had lasted for less than forty-eight hours.

It is probably of interest to note that the infant who did not partake of the chicken on either occasion did not manifest any variation from normal.

Also, it should be noted that the chicken on both occasions had been purchased as separate sections such as breast, legs, etc., so that the probability of parts of several chickens having been eaten at both meals is not at all unlikely.

The symptomatology and the circumstances were so suggestive of Newcastle Virus Disease, that blood specimens were taken on Patients No. 2 and No. 3 on October 2, 1948. These specimens were sent to the U. S. P. H. S. Virus Laboratory at Montgomery, Alabama, for a Neutralization Test against Newcastle Disease Virus. These two samples were reported simply as

The Author

● **Dr. McGough, New Philadelphia, Ohio, is a graduate of George Washington University School of Medicine, 1938, and of Johns Hopkins University School of Hygiene and Public Health, 1948; and is now health commissioner of Tuscarawas County General Health District.**

Submitted November 18, 1948.

Note: The author is indebted to Beatrice Howitt, Bacteriologist in charge of Virus Research, and to the Virus Laboratory Division of the United States Public Health Service at Montgomery, Alabama, for the Neutralization Index Tests which are included in this report.

being "positive," and a "repeat" sample was requested for confirmation of diagnosis and to note the convalescent titer.

Accordingly, a second specimen of blood was taken from Patient No. 3 and forwarded to the Virus Laboratory on October 15, 1948. The Neutralization Index on this sample was reported as 17,400.

As described by Howitt, et al., in the September issue of the *American Journal of Public Health*, the method of virus dilution follows the standard recommended for neurotropic viruses in the U. S. Army Laboratory Manual. The result is considered negative if the Neutralization Index is under 10, equivocal if between 10 and 50 and positive if over 50.

Because of the fact that at least several other persons in the community had had practically identical symptomatology at approximately the same time, blood samples were likewise forwarded for examination. The report on these specimens is as follows:

Name	Date Bled	Neutralization Index	Result
C.B.	10-18-48	1480	Positive
A.M.	10-20-48	3170	Positive
C.P.	10-20-48	100	Weakly Positive
A.S.	10-15-48	Bacterial contamination of Serum	
E.S.	10-15-48	100	Weakly Positive
J.S.	10-15-48	1000	Positive
B.Y.	10-14-48	603	Positive

Incidentally, all of the above-mentioned seven patients reported eating chickens, probably of local origin. None of these persons are poultry raisers.

DISCUSSION

The clinical picture in all of the above-mentioned ten patients is typical of Human Newcastle Virus Disease.

The Neutralization Index has confirmed the clinical impression in eight of these ten cases, the test not having been attempted on one case, and bacterial contamination of the glass tube preventing proper use of the blood in the remaining instance.

So far as we have been able to discover, this constitutes the first report of Newcastle Virus Disease in humans in the State of Ohio. Avian pneumo-encephalitis has been reported from all but four of the states, according to the "Report on Newcastle Disease" in the *Bulletin of the Bureau of Animal Industry*, July 1, 1948.

In the three cases which were studied more thoroughly from the epidemiological viewpoint, there is a complicating factor in that chicken was eaten by the same three persons on successive Sundays. If poultry is to be considered the vector in all of these cases, it appears reasonable to assume that the incubation period for Patient No. 1 was 72 hours (three days), and for Patient No. 2, 120 hours (five days).

If Patient No. 3 was infected at the same time as the other members of his family, then the incubation period in his case is nine days. If he was infected at the second chicken meal, then the incubation period would be 60 hours (two and one-half days).

Obviously, one cannot generalize on the basis of so few cases. But it does appear logical to state that the incubation period for Human Newcastle Virus Disease may be as short as two and one-half days and that it may be at least as long as five days.

Considering the fact that the suspected chickens or chicken parts were in all instances stated to have been "thoroughly cooked," it might be well to investigate other possible preventive measures where gross appearance is not sufficient to forewarn a prospective cook or diner that the chicken has had Newcastle Virus Disease (avian pneumo-encephalitis). If this disease should continue to cause human morbidity it might be worthwhile to require certification of poultry by an accredited inspector before such poultry could be sold as food.

SUMMARY

A series of ten cases giving the clinical picture of Human Newcastle Virus Disease has been reported as occurring in Tuscarawas County, Ohio.

An epidemiological study of three cases suggests that the incubation period varies from two and one-half to five or more days.

The Neutralization Index has confirmed the clinical diagnosis in the eight cases on which the test was made, the index ranging from 100 to 17,400.

Facts About Nutrition

Iron is an indispensable nutrient. It is a necessary constituent of hemoglobin as well as a number of oxidation-reduction enzyme systems essential for the life of cells. Some of these are catalase, peroxidase, the cytochromes, and cytochrome oxidase. However, in order for the body to convert the iron to hemoglobin, another indispensable dietary nutrient must be present, namely, copper. Hemoglobin is a conjugated protein and is a complex compound composed of hemo, iron protoporphyrin, and globin. All of the indispensable amino acids which comprise the globin molecule must be provided by dietary protein. Add to the foregoing the role of folic acid in stimulating the hematopoietic system, and one arrives at the point where the interrelationships of various dietary essentials have ceased to be of interest solely as academic pursuits but are of immense value in preventive as well as clinical medicine.—New York State Journal of Medicine, Vol. 48, No. 22, November 15, 1948.

Recent Advances in Research and Treatment of Multiple Sclerosis

I. MARK SCHEINKER, M. D.

MULTIPLE sclerosis was considered by its first describers, of almost a century past, as something of a curiosity. With advancement in knowledge of the disease and with progressive refinements in diagnosis, it is recognized today as one of the commonest among neurologic diseases.

At the Boston City Hospital, for instance, in the five years from 1931 through 1935, the diagnosis of multiple sclerosis was made in 203 cases, whereas diagnoses of poliomyelitis during the same period totaled half that number, namely 101 cases.

And yet enormous sums are expended on the study of poliomyelitis, the while multiple sclerosis is still referred to in some quarters as a rare disease. Credit for the first complete clinical and pathologic account of multiple sclerosis is due the eminent French neurologist, Charcot. He first became familiar with the progress of the disease through daily observation of his housemaid, who had nystagmus, intentional tremor, and scanning speech. Ironically enough, Charcot also was a "pioneer" in misinterpreting the condition, for he diagnosed the case as tabes dorsalis.

By means of free hand sections stained with primitive methods, he recognized the essential histopathologic features of sclerotic plaques, and emphasized the loss of myelin sheaths, the preservation of axis cylinders and the proliferation of glia.

Throughout the 80 years elapsed since Charcot's original description of multiple sclerosis, little has been added to the histopathology of the disease. This deficiency has been due to the futility of seeking facts concerning the nature of the disease in repeated studies of the sclerotic plaques. These sclerotic lesions, it is now understood, are to be considered as the late sequelae of the disease in the final process of glial scar formation.

One might just as profitably study a small skin lesion healed by scar formation, in an attempt to learn whether the initial lesion was caused by injury, infection, or some other pathologic conditions. There is nothing specific or pathognomonic in any process of scarring.

Recent research, definitely at variance with this erroneous approach to the problem, has yielded promising results.

Presented before the Section on Nervous and Mental Diseases at the 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, April 1, 1948.

The Author

● Dr. Scheinker, Cincinnati, Ohio, is a graduate of the Medical School of the University of Vienna, 1929; diplomate, American Board of Psychiatry and Neurology; member, Association for Research in Nervous and Mental Diseases, American Association of Neuropathologists, American Psychiatric Association, American Academy of Neurology; attending neurologist and neuropathologist of the Cincinnati General Hospital; assistant professor of neurology and neuropathology, University of Cincinnati College of Medicine.

Three new avenues of research, crystalized during the last decade, are briefly summarized herewith:

1. Putnam and his co-workers[1] were the first to assign a primary rule to vascular lesions in the pathogenesis of multiple sclerosis. They succeeded in producing patches of demyelination by intravenous injection of various substances, e.g., tetanus toxin. The similarity between such lesions and the foci of multiple sclerosis indicated the possibility that the lesions of multiple sclerosis might be produced by a local circulatory disturbance, "apparently of the nature of an obstruction on the venous side."

2. From 1937 to 1940 the author[2] had the opportunity to study a large number of cases of multiple sclerosis accumulated in the laboratory of La Salpetrière in Paris since the early days of Charcot. The chief aim of the author's work was to determine the nature of the earliest histopathologic lesions, and thus to obtain some information concerning the pathophysiologic mechanism of plaque formation. In order to trace the process from its beginning, the histologic analysis was limited to lesions which were not visible to the naked eye. Thus, all grossly visible plaques in the stage of scarring were discarded, and sections were prepared from grossly intact regions of the brain and spinal cord.

About two-thirds of all the initial small lesions were found in close proximity to small veins, which were extremely distended and displayed signs of stasis and congestion. Some of the veins were occluded by small thrombi composed of fibrin threads and large masses of

agglutinated platelets. Only occasionally did the vessel walls display degenerative alterations secondary to inadequate blood circulation.

In about one-third of the cases perivascular accumulation of cells was observed. The majority of perivascular cells were identified as gitter cells; others were lymphocytes.

This study thus demonstrated in rather striking fashion the frequent association of the early lesions of multiple sclerosis with vascular disturbances.

Similar observations have been made by Putnam (1937),[3] and Dow and Berglund (1942).[4]

Now, what is the correlation between the vascular disturbances and the early lesions of multiple sclerosis?

According to Putnam, there must be a primary change in the coagulability of the blood or changes in the intimal lining of the blood vessels which lead to vascular thrombosis.

It is my own impression, however, that the primary mechanism responsible for the vasoparalytic distention of the smaller blood vessels is due to disturbed vasomotricity of the cerebral blood vessels. Recent studies (Scheinker[13]) have shown that a vasoparalytic reaction may be caused by various etiologic factors, such as infection, trauma, emotional shock or similar conditions. Prolongation and repetitions of the functional vascular disturbances might lead to an irreversible state of vasoparalysis and stasis. The retardation of the blood flow may lead to thrombus formation and cause damage to the nerve tissue by permanent impairment of the blood supply.

This proposed interpretation of the pathophysiologic mechanism of multiple sclerosis would explain the detrimental influence of infectious disease, trauma, emotional distress and related conditions which so often precede or usher in the first clinical manifestations of multiple sclerosis.

The list of exogenous factors responsible for a vasoparalytic reaction of the cerebral blood vessels thus corresponds closely with the list of exogenous factors that so often precipitate the onset of exacerbation of multiple sclerosis.

This same mechanism might best explain the transient nature of some of the clinical symptoms, as well as the remissions and exacerbations of the disease.

In a recent study Franklin and Brickner[11] reported 18 cases of multiple sclerosis in which brief constrictions of retinal arterioles were actually seen during an ophthalmoscopic examination. In three cases alternate opening and closing of an arteriole were noted. Associated with the arteriolar constrictions were scotoma and occasional reduction in visual acuity.

3. In 1935, Rivers[5] and his co-workers opened a new and very promising avenue of research by the reproduction of demyelinating conditions in experimental animals. With repeated intravascular injections of aqueous emulsions from normal rabbit brains into monkeys, Rivers[5] obtained pathologic lesions characterized by focal loss of myelin. The cerebellum, pons and the periventricular regions were more affected than were other portions of the cortical nervous system. Ptosis of the eyelids, mask-like expression of the face, facial paralysis, blindness and ataxia were the usual clinical signs and symptoms noted in the animals.

The mechanism productive of these experimental lesions offers a fruitful field for speculation. A series of experimental studies reported by Ferraro and Jervis,[6] Morgan,[7] Kabat, Wolf and Bazer,[8] and Morrison[9] made it clear that demyelinating lesions, similar to those observed in postvaccinal or postinfectious encephalomyelitis, may be experimentally produced in laboratory animal by repeated injections of heterologous brain antigen. Serologic studies have demonstrated that, with the use of homologous antigen, antibrain antibodies may be produced.

An evaluation of these interesting experimental studies, in their relationship to multiple sclerosis in man, is extremely difficult. It would rest, in part, upon the relationships among the various forms of demyelinating diseases.

Some investigators, like Ferraro and Putnam, as well as others, believe that disseminated encephalomyelitis is an acute form of multiple sclerosis.

The acceptance of this point of view means that the experimental reproduction of multiple sclerosis is an accomplished fact. However, there are differences, both pathologic and symptomatologic, between disseminated encephalomyelitis and multiple sclerosis. Therefore, to regard the experimental reproduction of multiple sclerosis as an actual achievement, is premature.

THERAPEUTIC CONSIDERATION

Of the many therapeutic measures currently advocated as promising methods of treatment of multiple sclerosis, only a few will be briefed here.

a) **Anticoagulant Drugs.** In 1947, Putnam and his co-workers[10] reported the results of treatment of 43 multiple sclerosis patients with dicoumarin for a period varying from six months to four years. The patients were given 150 mg. of dicoumarin for the first three days, the average daily dose thereafter being in the range of 50 to 100 mg. After discharge from the hospital the patients were given a maintenance dose of dicoumarin depending on the blood prothrombin level and sufficient to raise the prothrombin time to 30 seconds.

The following results were obtained: Twenty-five patients suffering from a remittent form

of the disease did not show any new symptoms or obvious acute outbreaks of the disease. Most of the 16 patients with the chronic progressive form of the disease continued in their downward course. In two cases the treatment was discontinued at an early stage.

Against the advantages of dicoumarin treatment are to be weighed certain disadvantages. It cannot produce improvement of symptoms, although it does possibly afford a certain degree of protection against serious future outbreaks; in order to obtain this possible protection, the treatment must be continued throughout the rest of the patient's life. The administration of dicoumarin requires a great deal of technical knowledge and skill, and depends upon reliable weekly determinations of the prothrombin time in order to avoid the dangers of hemorrhages.

b) **Vasodilating Drugs.** Based upon the clinical assumption that some of the transient symptoms of multiple sclerosis are caused by vasoconstriction of cerebral blood vessels, the use of vasodilating drugs has been advocated. In 1942, Horton introduced histamin as a powerful vasodilator of the cerebral arterioles and venules in the treatment of multiple sclerosis. Since 1942 more than 55,000 intravenous histamin injections have been given at the Mayo Clinic to patients with multiple sclerosis. The results obtained are debatable.

Franklin and Brickner[11] have used fast-acting vasodilating drugs such as papaverine hydrochloride, syntropan and aminophylline in tolerance doses in cases of multiple sclerosis having scotomas and reduction in visual acuity caused by constriction of the retinal blood vessels. In most cases the vasodilating drugs caused prompt, temporary reduction of the constrictions and of the size of the scotomas.

No clear-cut, indisputable effects were observed as a result of administration of vasodilating drugs, in my own experience. The rationale for their use in cases of multiple sclerosis seems doubtful. Although it is true that vasospastic phenomena may occasionally take place, it is also true that they last but a short period and are followed by more prolonged vasoparalytic phenomena. These may result in stasis and retardation of circulation, and thus may be responsible for tissue damage caused by hypoxia. It is the prevention of stasis and slowdown of circulation which should dictate the kind of treatment prescribed for multiple sclerosis.

PERSONAL OBSERVATIONS

To meet, in advance, the objections and criticism that hold true for any proposed treatment of multiple sclerosis the following points require clarification: Because of the frequency of spontaneous remissions inherent in the nature of the disease, every beneficial result is to be appraised, not without a just proportion of skepticism. Statistical data are, therefore, of questionable value. Needless to say, observation of each case over a period of many years, if possible, would conform to the strictest of criticism's requisites and satisfy the most exigent critic. Why so ideal a possibility does not have its counterpart in fact, except in the rarest of instances, needs no explanation.

The foregoing must serve as an apology for the presentation of data, accruing from personal experience in the treatment of multiple sclerosis, though such data admittedly are in terms of patients numbering several dozen instead of the ideal several thousand and though, too, such data relate in terms of treatment to a period much shorter than the ideal two or three decades.

A clinical study of a series of 40 cases of multiple sclerosis yielded the following observations:

1. The large majority of cases of multiple sclerosis show a marked degree of arterial hypotension. Repeated measurements yielded systolic and diastolic pressures far below normal values.

2. A striking myasthenia-like fatigability of the skeletal muscles is an extremely frequent complaint of most patients. Almost without exception, they seem to have some degree of muscle power in the early morning hours, becoming increasingly weak and tired throughout the remainder of the day. The rapid loss of muscle power may, in some cases, be easily recovered after a short period of rest. Difficulties in walking, speech disturbance, tremor and locomotor ataxia, as well as difficulties in swallowing, become more pronounced in the afternoon and evening hours.

3. A striking influence of morale and emotional factors upon the extent and severity of symptoms is evident. A large proportion of cases of multiple sclerosis are in a permanent state of anxiety and tension, and show a dire need for help and guidance. The initial success of any "new" treatment applied to patients afflicted with multiple sclerosis is based primarily upon this craving for guidance and a marked susceptibility to suggestive psychotherapy.

On the other hand, there is a striking correlation between emotional instability and the severity of a given symptom or symptoms. On repeated occasions one may witness a sudden onset of paralysis following an increase in tension or anxiety. I could cite here, if space would permit, several personally observed instances in which an emotional upset was of profound importance with respect to onset of a series of new symptoms or in explanation of an accentuation of those already present.

All these clinico-pathologic observations were taken into consideration in formulating the pro-

cedure of treatment. The therapeutic measures advocated may be divided into:

1) Those founded upon the author's theory of the pathogenesis of the disease. They are aimed at elevation of blood pressure and stimulation of circulation for the purpose of counteracting the vasoparalytic vascular phenomena which result in stasis and thrombosis of some of the small cerebral veins and capillaries. Daily administration of ephedrine sulfate in small doses, combined with such cardiac stimulants as caffein or small doses of alcohol, appear in some cases to give satisfactory results. In some more advanced cases standardized extracts of the adrenal cortex (Eschatin desoxycorticosterone acetate and others) are on trial.

2) Therapeutic measures aimed at alleviating the myasthenia-like fatigability and muscle weakness. Excellent results have been obtained in a number of cases with generous administration of prostigmin. The patients were given 15 mg. of prostigmin bromide three times daily and subcutaneous injections of 1 to 2 ampules of prostigmin methylsulfate (1:2000) three times weekly. The daily administration of prostigmin was of tremendous help in combating the increased fatigability, in relaxing spastic muscles and facilitating voluntary innervation.

Supplementing the generous use of prostigmin, there are prescribed daily muscle exercises as a part of a broad plan of muscular re-education and rehabilitation. A large series of muscle exercises were developed, and these are prescribed individually, depending upon the disabilities of each patient. They have proved effective in a number of cases in the restoration of muscle power and in facilitating recovery in function of the weakened limbs. Needless to say, while patients with less pronounced weakness have revealed relatively rapid beneficial results and considerable improvement, the response in patients with severe and longstanding paralysis has been much slower and less satisfactory.

I know that some of these measures will shock those who still believe that the best thing to do for a patient afflicted with multiple sclerosis is to give him as much bed rest as possible.

In my own experience this unfortunately popular regime serves to accelerate the weakness, spasticity, and uselessness of the involved muscles, and at the same time has a disastrous effect upon the morale of a patient who feels abandoned and deprived of any hope of active help.

3) Finally, but not least, a series of therapeutic measures, that may be summarized under the heading of "morale building." It may strike one as a paradox that a strictly organic disease, like multiple sclerosis, should not only favorably react to, but in some instances require a strict application of psychotherapeutic measures. The general attitude of a physician facing a case of multiple sclerosis is still too often that of a frankly-admitted inability to do anything constructive. This honest pessimism relieves the physician from the burden of responsibility but plays havoc with the patient's symptoms and renders him incapable of fighting his disease. To my way of thinking, the physician who assumes responsibility for treatment of multiple sclerosis is confronted with the two-fold responsibility of treating both the disease itself and the problems which the disease poses to the patient. It is my conviction that helpful guidance, enabling the patient to deal with his disease in an effective manner, is a condition sine qua non for successful treatment of the disease itself. Like any other serious personal problem, multiple sclerosis should be presented to the patient as a not-hopeless challenge requiring active cooperation with the physician. To assist the patient in discovering the satisfaction of coping with his liability is a precious prerequisite to further therapeutic measures, predisposing to the successful outcome of the team efforts of both patient and physician.

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It is wise to assume that all subjects who show a positive tuberculin test before the age of three years have active infection. In such children, the infection has hardly had time to become inactive.—Joseph D. Wassersug, M. D., N. E. Jour. Med., July 3, 1947.

Recent Advances from a Study of Multiple Sclerosis*

CHARLES D. ARING, M. D.

DR. SCHEINKER has reviewed for us the problem of multiple sclerosis and has given his own interpretation that the mechanism responsible for the disease is disturbed vasomotricity of the smaller cerebral blood vessels. Recent studies have shown that a vasoparalytic reaction may be caused by various etiologic factors, such as infection, trauma, emotional shock, and other conditions. Prolongation or repetitions of functional vascular disturbance might lead to an irreversible state of vasoparalysis and stasis. The retardation of the blood flow may go on to thrombus formation and cause damage to the nervous tissue by such permanent impairment of blood supply.

As to the many therapeutic measures currently advocated, he discussed both the anticoagulant drugs and the vasodilating drugs, and reported good results in a number of cases in which the following therapeutic measures were applied: (1) Measures founded upon his theory of the pathogenesis of the disease. They are aimed at elevation of blood pressure and stimulation of circulation for the purpose of counteracting the vasoparalytic phenomena which result in stasis and thrombosis of some of the small cerebral veins. (2) Therapeutic measures aimed at muscle rehabilitation and reeducation (systematic muscle exercises). (3) Alleviation of the myasthenia-like muscle fatigability by use of large doses of prostigmin. (4) A series of therapeutic measures summarized under the heading of "morale building" and "psychotherapy." Dr. Scheinker insists that the physician who assumes responsibility for the treatment of a case of multiple sclerosis is confronted with the two-fold responsibility of treating both the disease itself and the problems which the disease poses to the patient.

Dr. Scheinker's challenging presentation reminds us of the steady accumulation of neurological diseases that have become amenable to psychotherapeutic techniques; and who can doubt that the majority of the therapeutic maneuvers that Dr. Scheinker has recommended fall under the heading of psychotherapy?

I would submit that neither Dr. Scheinker nor we know what he is doing pharmacologically with several of the drugs that he has mentioned, and I for one would not know how to interpret exactly his words ". . . stimulation of the circulation for the purpose of counteracting the vasoparalytic vascular phenomena . . ." When one examines critically the drugs that he is using, one may sympathize with my confusion.

It must be taken into consideration that when repeated doses of ephedrine are given at frequent intervals, cardiac stimulation becomes less and less prominent, and ultimately depression of the heart may occur.

Caffeine too, has multiple effects as far as the vasculature is concerned; one of them being the potentiality of cerebral vasoconstriction in response to the blowing off of carbon dioxide by the induced hypernea. I can just as easily imagine small doses of alcohol decreasing blood pressure since the main effect is a peripheral vasodilatation; certainly, the blood pressure does not change significantly with moderate doses of alcohol.

Prostigmin is perhaps the most overworked and poorly understood drug of the lot since its mention by Paul DeKruif in the *Readers Digest* a year or two ago. This relatively expensive substance would probably be better replaced by good old acetylsalicylic acid in 5 grain amounts. If the former has any therapeutic use in muscle disorders besides myasthenia gravis, it may depend on its mildly analgesic action, a property of prostigmin not generally known, and the psychotherapeutic effect that surrounds the taking of every drug. It is with the latter effect that I believe Dr. Scheinker is helping his patients.

It seems that I may render the best service in the space allotted by pointing to those conditions previously in the province of the neurologist, the therapy of which now in the main is psychotherapeutic or adjunctive thereunto. Mind you, I did not say that the properly

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* Discussion of Dr. I. Mark Scheinker's paper on "Multiple Sclerosis" as presented before the Section on Nervous and Mental Diseases at the 1948 Annual Meeting of The Ohio State Medical Association at Cincinnati, April 1, 1948; and which appears on page 27 of this issue.

trained neurologist may not administer such therapy.

We might begin with the narcolepsy-cataplexy syndrome, that galaxy of symptoms which for so long defied the searches of the pathologist; as well it might, since with them, the personality avoided coming to grips with what was for it a most distasteful problem. There is no longer doubt that one may cure these patients with psychotherapy, not just any kind of psychotherapy but rather the type that elucidates the reasons why the symptom is needed.

Then there is that vast collection of the chronically painful conditions which has hitherto been mostly considered, inadequately to be sure, from the standpoint of a conducting system. The receptors were poked at and sensory pathways disrupted, and if this were ineffectual, newer pathways were imagined or conjured up in some cases; rarely was that sounding-board of the organism, the emotions, considered in the analysis. It was as though the human being were a bunch of wires leading hither and yon and that which was conducted was something passed along unchanging in all its physical pristineness.

Today there is little question that any persistant or intermittently occurring pain that has plagued the patient for a prolonged period of time requires psychological investigation. Migraine with its myriad variants including so-called histamine headache, atypical facial neuralgia and the like, is a case in point; but chronic pain anywhere, if the reason remains unelucidated, requires psychological insight. I feel safe in saying, as a sufferer of migraine, to say nothing as an expert on the subject, that there is no cure for this particular disorder short of psychotherapy, excepting perhaps the aging process. Carried to its ultimate, the latter, as the poets have so beautifully made out, is a cure for all ills.

Those neurological complications surrounding trauma require expert psychiatric knowledge; the shell-shock and blast of World War I have metamorphosed into the psychoneurotic disturbances of World War II. As has been shown so beautifully by Simons and Wolff, post-traumatic headache usually is a psychological problem; others including ourselves, working with the chronically disabled limbs of the employee who obtained his injury in a setting of resentment and hostility be it ever so subtle, find that insight is required by the patient into the meaning of the symptom to himself, or cure is impossible.

I am no longer satisfied that the physician has given his full measure when he administers anti-convulsant medication to the patient with epilepsy. Without exception, these people that I have followed closely have underlying neurotic disturbances which, if they are not the cause of the epilepsy, have much to do with the precipitation of the fit. The epileptic who may encompass it receives psychotherapy at my hands, and I have no hesitancy in saying is better for it.

The treatment of aphasia previously extraordinarily unsatisfactory, received some impetus with the report that certain cases may obtain relief with the technique of amytal or pentothal interviews, relief which may persist after the effects of the barbiturate have worn off. In my limited experience with this therapeutic adjunct, several barbiturate interviews may succeed where one may fail. We all know that considerable anxiety underlays or overlays the aphasia syndrome and by dealing with it rather than with the presenting symptom, we may assist these persons to speak. My own therapy of the aphasias on any other basis had been singularly disappointing.

We have all heard what is being done in the therapy of vascular hypertension with psychotherapy, and it should be kept in mind that there are a few neurological disorders predicated on hyperpiesis.

Neurology has become a specialty dealing essentially with chronic disease. Therapy that aims at relief or more important at prevention, requires our sympathetic orientation to psychology and psychiatry. The program of rehabilitation that has recently gained so much attention with the war requires considerably more than physical techniques. It is not widely recognized that the dynamics of transference and countertransference are possibly the single most important factor in any program of so-called, physical rehabilitation.

This point has been recognized by Dr. Scheinker in his efforts toward treating multiple sclerosis. Langworthy has carried the thesis a step further in his paper on the "Relation of Personality Problems to Onset and Progress of Multiple Sclerosis."[1] In a study of women with multiple sclerosis, he found emotional problems of magnitude, considerably predating the onset of the disease, in fact at a pre-adolescent level. It has been known for a long time that these patients have pronounced vasomotor instability in the extremities. It is a question, in view of all the evidence to date that has pointed to the implication of the blood vessels in multiple sclerosis, whether vascular changes in the brain related to neurotic difficulties might lead to the symptom complex.

At present, surely we have nothing better to offer these patients than psychotherapy, and in this case insight psychotherapy would seem to be required. At this stage of our

development, I would hazard the guess that the latter will offer the best chance at prevention of subsequent attacks.

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Comments on this Discussion by Dr. Scheinker

I am grateful to Dr. Aring for his elaboration upon my observation concerning the influence of morale and emotional factors upon the extent and severity of symptoms in cases of multiple sclerosis. We are in agreement that patients with multiple sclerosis not only react favorable to, but in some cases require strict application of psychotherapeutic measures.

However, it is difficult for me to follow him in his generalization indicating psychotherapy as the only effective element in the proposed treatment of multiple sclerosis and it is rather surprising to hear Dr. Aring carry his generalizations so far as to suggest psychotherapy as the omnipotent method of treatment of most organic neurologic diseases.

In view of Dr. Aring's critical attitude toward the use of prostigmin because, as he claims, it has only "analgesic action," his statement that "Dr. Scheinker knows as little as we all do" about the action of prostigmin and ephedrine sulfate, compels me to a protest.

Some of us should and do know that numerous experimental investigations have conclusively established that prostigmin inhibits the action of cholinesterase and thus promotes the accumulation of acethylcholine in the tissues. Moreover recent studies by Ricker,[1] Heymans,[2] and others have indicated that prostigmin has a directly stimulating effect on muscle tissue. Needless to observe here, it is generally known that the striking efficacy of prostigmin in myasthenia gravis has nothing to do with any "analgesic action" of the drug. According to the competent view of Viets[3] the primary aim in the administration of prostigmin in cases of myasthenia is to offset the activity of the cholinesterase which produced excessive or too rapid destruction of the acethylcholine. The maximum efficacy of prostigmin in cases of multiple sclerosis is to be attained only by combining its application with an elaborate system of muscle exercises.

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Vitamin Balance—Preoperative

It is well accepted now that there is a high incidence of hypovitaminosis in patients who have cancer. This alteration in vitamin metabolism parallels the changes in nitrogen metabolism but the cause for the deficiency is not understood. Keifer believes that the vitamin B complex is perhaps the key factor. He says: "Vitamin deficiencies, particularly those involving the vitamin B complex group of vitamins can profoundly impair digestion and absorption of essential food elements. Since malabsorption further diminishes the subject's vitamin intake, a vicious circle is established."

Golden has suggested that the intramural nervous system is the most probable medium through which nutritional deficiency affects the intestinal tract. Torda and Wolff have demonstrated that when cholinergic nerves are stimulated they liberate both acetylcholine and thiamine and that the latter increases the effect of acetylcholine on the intestine and circulatory apparatus of the cat. Chemically these two compounds are closely related, therefore it is reasonable to believe that they may have a synergistic function. These facts furnish a reasonable explanation of the mechanism of paralytic ileus in the presence of thiamine deficiency and of the favorable response to administration of large doses of thiamine chloride.

Leithauser reported a series of cases of adynamic ileus with marked abdominal distention, which failed to respond to mechanical decompression and drugs, but which were promptly cured by administration of the vitamin B complex.

Ravdin and Zintel and a host of other writers confirm the need for supplemental vitamin intake. The principal needs are: ascorbic acid; thiamine, riboflavin, and nicotinamide of the B complex; and vitamin K. They may be given orally in the form of one of the multivitamin preparations but to assure absorption the parenteral route is probably best. It is suggested that heavy dosage be given, for example .5 to one gram of ascorbic acid, from 10 to 30 mgm. each of thiamine and riboflavin, from 200 to 300 mgm. of nicotinamide, and five mgm. of vitamin K be given daily beginning three or four days prior to operation. A convenient way to administer all of the above (except the vitamin K) is to add the entire contents of an ampule of Solu-B with vitamin C (Upjohn) to the glucose solution just prior to its administration.—John G. Matt, M. D., Tulsa, Okla., Jrnl. of Oklahoma State Medical Association, Vol. 41, No. 11, November 1948.

Personal Observation on the Treatment of Multiple Sclerosis*

HOWARD D. McINTYRE, M. D.

RECALLING a remark made by Judge Ferdinand Pecora of New York, my esteemed colleague, Dr. Aring, has "distilled a little drop of poison" into this discussion. It is my personal opinion that any paper dealing with the treatment of multiple sclerosis should only be read before this section in executive session. To release such a paper to the public press will serve the purpose of presenting us with another Sister Kenny problem with all its ramifications and repercussions. One has only to recall the experience and ideas of Purves Stewart as to the cause and treatment of multiple sclerosis in order to recognize the difficulties involved. Purves Stewart thought that with the ultramicroscope that he had isolated the cause of multiple sclerosis. He called the causative agent of this disease the spherule insularis. In the ultra-microscope Dr. Stewart saw globulin bodies which were normally present in the spinal fluid of multiple sclerosis and other diseases. He called these bodies the spherule insularis and he thought they were the etiologic agent of multiple sclerosis. He even claimed to have perfected a vaccine which he claimed would cure the disease. The result of this work was that all the cases of multiple sclerosis in the empire made a trek to London only to suffer the usual disappointment because research by other workers showed that the spherule insularis was merely the globulin particles in the spinal fluid in cases of multiple sclerosis. Stewart made a considerable amount of money before events caught up with him. His excursion into pseudo-science cost him his excellent neurological reputation.

NO SPECIFIC TREATMENT

I have treated hundreds of cases of multiple sclerosis using any form of treatment that had any scientific claim in its favor. In all the years that I have treated multiple sclerosis I have published one sentence on the treatment of multiple sclerosis, namely, that at the present time there is no specific treatment for this disease. The only treatment at the moment is purely supportive and symptomatic.

At the present time there is no specific treatment for multiple sclerosis for the reason that the cause of the disease is not known. Any treatment at the moment is purely supportive. Up to the present time, all investigations of the etiology of the disease have proved fruitless. It is remarkable that a disease with such a simple uniform pathology, namely, the plaque, should have defied many of the best minds of medicine as to its cause.

The lines of research as to etiology so far pursued are, the infectious theories in which the streptococcus, spirochete, and the various viruses have been implicated, the metatyphoid and lead poisoning theories of Oppenheim, the theory of vascular origin originally broached by Pierre Marie and extended in later years by Tracey Putnam, the theories of trauma, biologic crisis, variation in weather, and barometric changes, the psychosomatic theory first advocated by the late Dr. Jelliffe, the degenerative theory of Hassan and Strumpell, the theories of parenchymal and mesoderman origin, the theory of the so-called "spherule insularis" advocated by Purves Stewart. All those theories have been weighed and found wanting.

NOT RARE

Multiple sclerosis is certainly not a rare disease. In the last twenty-five years of my practice I have seen over 600 cases of this disease and I have had the opportunity to observe over 300 of these cases over a twenty-year period.

As to the vascular origin of multiple sclerosis Putnam and Scheinker have reported many instances of plaques related to blood vessels. Other observers, however, have counted nine plaques not related to blood vessels to one plaque in close proximity to a blood vessel. Dr. Putnam believes that increased coagulability of blood is responsible for thrombi on the venous side of

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* A discussion of Dr. I. Mark Scheinker's paper on "Multiple Sclerosis" as presented before the Section on Nervous and Mental Diseases at the 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, April 1, 1948; and which appears on page 27 of this issue.

the circulation. Dr. Scheinker believes that the formation of plaques is due to vasoconstriction followed by vasoparesis and thrombus formation. There is much to be said in favor of acute vascular episodes in multiple sclerosis. Brickner has observed with the ophthalmoscope vasoconstriction followed by vasodilatation in the retinal arteries accompanied by appropriate scotomata in the visual fields of patients with multiple sclerosis.

I have observed transient scotomata and other focal episodes in multiple sclerotics under emotional stress; for example, a woman, during the course of a particularly irritating divorce proceeding, a sudden monoplegia in a sclerotic after a fright. In this connection, many patients who have discontinued the use of tobacco can produce a scotoma or other focal symptom which has been present and is in remission by smoking one cigarette. I have made peripheral vascular studies on patients with multiple sclerosis. Many of these patients, but not all, showed intense peripheral vasospasm. In this connection it is interesting to note that many of the older theories of multiple sclerosis, namely those of trauma, chilling, infection, biologic crisis, emotional shock, etc., can be related to the vascular theory of this disease. Again, the apoplectic onset of focal symptoms in multiple sclerosis adds weight to the theory of vasoconstriction and vasoparesis. I have observed that the focal symptoms of multiple sclerosis in the remitting type are of apopletic onset in over sixty per cent of all cases. We must no longer consider multiple sclerosis as a chronic progressive disease. It is rather a disease punctuated by many apoplectic episodes.

METHODS OF TREATMENT

As to the treatment of multiple sclerosis, I have been engaged in the treatment of this disease for the past twenty years. I have employed the following methods:

(1) Fever treatment has been used in twenty cases. Only one case achieved a remission. The other cases developed the chronic progressive type of the disease. I would certainly condemn the typhoid vaccine treatment of retrobulbar optic neuritis of multiple sclerosis as all such cases improve spontaneously achieving normal or serviceable vision. The only case of permanent blindness that I ever saw in retrobulbar optic neuritis was in a patient with multiple sclerosis who had been treated with typhoid vaccine.

(2) Intravenous histamine by the drip method has been employed in thirty cases. The results are indifferent, however, three moderately advanced cases insisted that they were better following the treatment. They felt stronger and were able to walk better following the treatment and although there was no appreciable difference in focal signs, the patient was functionally better. These patients at a later date returned and asked for a second course of treatment when they felt that they were getting worse.

(3) One hundred and two cases have been treated over a ten-year period with quinine hydrochloride and vitamin B-1 and liver extract. The rationale for this therapy is as follows: Brickner has shown that the spinal fluid in patients with multiple sclerosis contains an excess of lipolytic enzymes. I have corroborated his observations in twenty cases. Brickner has further observed that quinine inhibits lipolytic activity in the spinal fluid of patients with multiple sclerosis. I have found a similar inhibitory effect on lipolytic activity in the spinal fluid of patients suffering with multiple sclerosis by vitamin B-1. It is also known that vitamin B-1 and certain factors in liver extract aid in the metabolism of myelin, therefore the use of quinine, vitamin B-1, and liver extract has a rational role in the treatment of multiple sclerosis.

(4) In the last four years I have used penicillin in the treatment of the initial episode of patients with multiple sclerosis. Our reason for this form of treatment was that if the streptococcal or spirochetal theory as to etiology was valid, then penicillin should have a beneficial effect. All of the initial symptoms disappeared after penicillin treatment, however, all of these cases have had other attacks since the treatment was given, showing that the treatment was of no value.

(5) One hundred and five cases have been followed over a fifteen-year period which have had no treatment. As far as could be determined these cases did as well as any series of treated cases.

DICOUMARIN

(6) I have used dicoumarin in only five cases with no better results than in any other type of treatment. Putnam's claims for this type of treatment are open to the same objections that can be raised against any type of treatment. It can be definitely said that if any type of treatment is used in the initial episode of the remitting type of multiple sclerosis that one hundred per cent of cures would be obtained. Putnam's observations have not lasted long enough to justify any claims made for his treatment. His claim that none of his patients with remittent multiple sclerosis developed new symptoms after the treatment is of no value because the elapsed time has not been sufficient to evaluate the result. Furthermore, dicoumarin treatment should be a hospital form of treatment, the technical difficulties as to the determination of prothrombin levels and the preven-

tion of hemorrhage are too great to make this form of treatment of any practical value.

DR. SCHEINKER'S TREATMENT

(7) Dr. Scheinker's treatment is based upon the assumption that patients with multiple sclerosis suffer with arterial hypotension and with a myasthenic-like syndrome. I have reviewed the medical records of blood pressure readings of patients with multiple sclerosis, and find that over fifty per cent of them have a normal blood pressure. As to the myasthenia, or rather fatigue in multiple sclerosis, it can be said that only those asthenic advanced cases show any appreciable fatigue. I have under observation many patients who are crane operators, steel rollers, garage mechanics, farmers, and others who engage in difficult physical occupations. They do not suffer with any myasthenic-like syndrome. I will agree, however, that too much rest is not good for the patient with multiple sclerosis except of course in those debilitated patients in the late stages of the disease.

As to the drugs employed by Dr. Scheinker, I have not found prostigmin to be of value in myasthenic states other than those of myasthenia gravis. I think that the relief of any fatigue symptoms in multiple sclerosis by prostigmin is purely psychological. Dr. Scheinker mentions alcohol as a circulatory stimulant. It is my opinion that alcohol is a vasodilator drug. In this connection it might be stated that tobacco is a vasospastic drug, and I have found that tobacco is the most harmful drug that can be used by patients with multiple sclerosis, and it is the one drug that must be interdicted in the disease.

Dr. Scheinker states that patients with multiple sclerosis suffer with depression. Some are depressed, however, just as many others are slightly euphoric and just as many, also, have normal moods.

MENTAL ATTITUDE

As to the psychotherapy of multiple sclerosis, I insist that no physician should manage these cases who has not had a wide experience with the disease. One should avoid if possible telling the patient that he has multiple sclerosis. A bad prognosis should never be given for two reasons, first, because of the bad emotional effect that it has on the patient, and secondly, because no one can tell what the prognosis of any given case of multiple sclerosis may be; only time will determine this. Much harm is done by physicians with limited experience who tell patients that they have multiple sclerosis and describe in detail all of the harrowing things that will happen to them as they become bedfast. It can be definitely said that a patient with multiple sclerosis who maintains a hopeful, cheerful attitude lives longer and suffers fewer attacks than does an anxious patient with the same disease.

* * *

Comments on this Discussion by Dr. Scheinker

Limited time prevents my replying to Dr. McIntyre's criticisms in full other than to express my regret that, in referring to "someone" who "proved" that in nine out of ten sclerotic plaques there was no evidence of vascular disturbances, he apparently missed the main point of my presentation. The point that I have tried to emphasize is definitely at variance with the erroneous approach to the problem via examination of the grossly visible sclerotic plaques in the end-stage of scarring. I demonstrated that only by analysing the early stage of the plaque-formation is one able to visualize the vascular alterations. They can be seen in almost every small lesion.

Dr. McIntyre questions the validity of my observation with regard to the myasthenia-like fatigability of patients with multiple sclerosis. His objections are based upon the observation that some of his patients "during the period of remission" are able to do physical work without abnormal signs of fatigue. This, of course, is perfectly correct. We all know that patients afflicted with multiple sclerosis lose many or most of their symptoms during periods of remission. Would the disappearance of diplopia, for example, during a period of remission contradict the validity of its existence as a characteristic clinical symptom for multiple sclerosis? The frequent presence of myasthenia-like muscle fatigability is, of course, observed in patients not in a state of remission.

Dr. McIntyre's acute fear that the proposed methods of treatment might result in another "Sister Kenny" affair seems to me to be ill-expressed and misdirected. There are many of us who sincerely believe that Sister Kenny did a good job in stirring up some "healthy" revisions of thinking directed at rigid or obsolete methods of therapy in cases of acute poliomyelitis.

Mental Health Necessary

Malaria, smallpox, tuberculosis, venereal disease, diphtheria many others, could all be got rid of—from the whole world, without any further knowledge or research, if we had mental health and social health in the people of the world, if enough people in enough places could think in factual terms and had good mental health. Nothing keeps the diseases alive except ignorance and shortsighted self-interest. Longsightedness would get rid of those things quickly. —Brock Chisholm, M. D., Mental Hygiene, July, 1948.

The Treatment of Venous Thrombosis with Heparin in Gelatin

CURTIS ARTZ, M. D.

THE importance of intravascular thrombosis and its attendant morbidity and mortality has been well recognized. Increased interest concerning this problem stems from three factors: The increasing age of the surgical patient, the expanding extent of surgical procedures, and the growing incidence of malignancy.

Despite the institution of such prophylactic measures as early ambulation, daily palpation of the calves and postoperative leg elevation and exercises, thrombosis or embolism may occur without warning.

Diagnosis in the incipient stage is the keynote to successful treatment. Any unexplained rise in the temperature or pulse rate should occasion a diligent search for deep venous thrombosis. The usual period of development of this complication is between the fifth and tenth day after operation; nevertheless, it may occur any time during the postoperative period.

At least 60 per cent of the very early cases will present leg signs.[1] The most common initial complaint is pain in the calf associated with tenderness. This tenderness is more accurately elicited by gentle palpation with the tips of the fingers pressing the relaxed calf perpendicularly rather than squeezing the muscles.

Swelling of the leg as evidenced by a slight increase in the circumference of the calf may be the first sign of thrombosis. Measurement of the calves at a fixed level below the knee should be taken daily in those patients with a particular predisposition to intravascular clotting. These include individuals with a history of thrombosis, fractures of the pelvis and femur, carcinoma of the pelvis or lower abdomen, elderly patients with obesity or blood dyscrasias, and bed-ridden patients who are unable to perform leg exercises.

Although Homan's sign (pain in the calf on acute dorsi-flexion of the foot) exists initially in less than half of the cases, it is of considerable diagnostic value when present.

Since a high percentage of pulmonary infarcts occur without premonitory signs of thrombosis, inquiry should always be made about the presence of pain in the chest. The patient is apt to describe the discomfort of a small infarct as "pleurisy" or a "stitch in the side." Routine daily determination of the vital capacity will give early clues to pulmonary pathology. Any appreciable decrease should arouse suspicion or serve as confirmatory evidence. Since the complication of pulmonary embolism is so often fatal, treatment should be instituted at the first indication of vascular pathology rather than delaying until the diagnosis is definitely established.

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TREATMENT

The therapeutic measures, anticoagulants and venous ligation, should be used, with individual case variation, as supplement to one another rather than as rival forms of therapy. Interference with the coagulation of the blood by the administration of an appropriate drug is a feasible approach to the problem of intravascular clotting. Ligation of the venous channels above the levels of the thrombus prevents further propagation of a fatal embolism. In those cases with recurrent thrombosis associated with benign pulmonary emboli, or elderly individuals with malignancy who must undergo multiple stage operations, or in patients whose predisposition to venous stasis will persist for a long time, bilateral interruption of the superficial femoral veins is the treatment of choice.

Since dicumarol has the advantage of oral administration, it has been the preferred anticoagulant. In addition to its disadvantages of delayed action, extreme variability of response, necessity of frequent prothrombin determinations, and the appreciable percentage of therapeutic failures, its use, particularly in surgical patients, is limited by the hazard of hemorrhage.

Heparin more nearly approaches being the ideal anticoagulant. It prevents propagation of the thrombus and promotes the establishment of collateral circulation by maintaining the patency of the adjacent vessels involved in the occlusive thrombotic process.

The difficulties associated with administration and the expense of heparin have been a deterrent to its use. For several years, it has been given by continuous intravenous drip. Bauer[2]

and Jorpes[3] advocate intravenous injections of 100 to 150 mgm. three times a day. Fifty mgm. intravenously every four hours has also been common practice.

In 1944,[4] Loewe and Rosenblatt published a preliminary report on the subcutaneous administration of heparin in Pitkin's menstruum. This medium of gelatin and glucose delays absorption so that 300 to 400 mgm. of heparin are sufficient to prolong the coagulation time to a therapeutic level for approximately 48 hours. The disadvantages associated with the intravenous administration of heparin have been eliminated by the simplicity of one subcutaneous dose every two days. Loewe[5] has also pointed out that an even and constant elevation of the coagulation time is preferable to the short, sharp rises produced by the intermittent intravenous method. Universal acceptance of this new menstruum has been slow because of the pain and local aching associated with its use.

In an attempt to eliminate these discomforts, certain changes were made in the original Heparin-Pitkin's formula. This improved preparation of heparin in gelatin* is roughly identical in therapeutic effect with Heparin in Pitkin's. It is prepared in two forms, plain and with vasoconstricter. The essential components of one cc. plain are: heparin, 200 mgm, gelatin, 18 per cent; and glucose, 8 per cent. The longer-acting vasoconstrictor type contains added ephedrine and epinephrine. These basic ingredients are essentially the same as in the original formula described by Loewe.

This new product has two distinct advantages. Administration is painless, and the concentration of heparin has been increased. Each cc. of heparin in gelatin contains 200 mgm. of the active principal in contrast to the 100 mgm. contained in Heparin/Pitkin's. This decreases by half the amount of substance which must be injected subcutaneously.

DOSAGE

The dose is fairly well standardized at 400 mgm. every other day; 200 mgm. plain and 200 mgm. with vasoconstrictor. Inasmuch as vasopressor drugs are contraindicated in arteriosclerosis and hypertension, some patients will require the plain form exclusively. Since the duration of effect of the plain preparation is relatively short, a daily dose of 200 mgm. is administered.

Occasionally, nervousness, headache and palpitation will be encountered from the vasoconstrictors. These minor symptoms are usually transitory and may be disregarded.

Larger doses of 500 or 600 mgm. are sometimes required. In patients weighing 200 pounds or more, it is preferable to increase the dose to 500 mgm. In the very obese, over 300 pounds, a 600 mgm. dose is recommended. If a very severe and extensive thrombosis is encountered, more than the usual 400 mgm. dose must be employed to insure maximum benefit. If the patients weighs less than 100 pounds, or if marked renal damage is present, 300 mgm. every other day will suffice.

When both the plain and vasoconstrictor types are given, they may be injected simultaneously in the same syringe. The contents of two vials (400 mgm.) deposited subcutaneously are the usual dose for the average patient.

At room temperature, the gelatin menstruum is solid, but at body temperature it liquefies slowly. Prior to administration, the ampule requires warming. This is best accomplished by holding it under the hot water tap until it becomes liquid. Two possible errors in the technique of administration may result in loss of valuable heparin. If the ampoule is heated in boiling water or over a flame, it may crack, and unless particular attention is paid to the maintenance of syringe-needle approximation, the increased pressure required for injection of the viscous menstruum may cause sudden separation of the syringe tip and needle hub. Administration through a 20-gauge needle is preferred.

It is imperative that the heparin be placed in the deep subcutaneous tissues. If given too deeply, in the muscle, hematoma formation with local pain may result. When it is placed superficially, bleeding will occur immediately beneath the skin causing some discomfort.

METHOD OF INJECTION

The preferred sites of injection are the anterior and lateral aspects of the thighs. These locations are easily accessible and usually present a well-formed subcutaneous layer. In cases of unilateral thrombosis, injection is made in the uninvolved leg. Pinching the subcutaneous tissues and skin to form a small mound facilitates accurate placement of the deposit of the menstruum in the deepest part of the subcutaneous layer. Unless the preparation has been unduly heated, injection is entirely painless.

The patient's course is followed by Lee and White venous blood coagulation times. A determination should be made before starting therapy and each day thereafter.

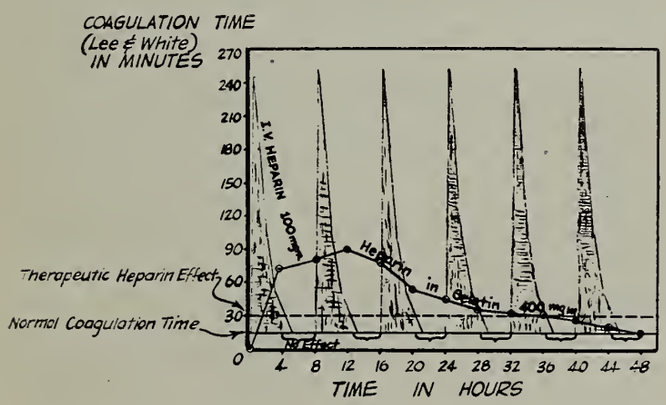
At the end of twenty-four hours, the amount of increase in the coagulation time is an indication of the patient's response to heparin. The determination at the 48th hour is usually normal. A significant increase remaining at this time is evidence of persistent heparinization and the next dose should be postponed for twelve hours.

In the event that termination of heparin

* Generously prepared and supplied to us for investigation by The Upjohn Company, Kalamazoo, Michigan.

therapy is required due to emergency surgery or troublesome hemorrhage, an ice bag may be applied over the injected area. The coagulation time will fall to normal within two hours and the heparin effect may be suppressed indefinitely.

It is felt that adequate heparinization occurs when the coagulation time is prolonged beyond thirty minutes. The original continuous intravenous drip method maintains the coagulation time beyond that figure. Bauer's[2] plan of giving 100 to 150 mgm. doses three times a day produces excessively high coagulation times for short periods with relatively long intervals of normal coagulability between injections. Heparin in gelatin permits the slow, even absorption of heparin which maintains a constant therapeutic prolongation of coagulation time. Graph I illustrates a comparison of the effects produced by the two methods of administration. One hundred mgm. of intravenous heparin will cause as increase in the coagulation time to approximately 250 minutes which promptly falls to normal in four or five hours. During the next three hours until the following dose, the coagulability of the blood is unaffected.



Heparin in gelatin, 400 mgm., 200 plain, and 200 with vasoconstrictor, will increase the coagulation time to approximately 90 minutes and allow a steady, slow return to normal in forty-eight hours.

Several thromboembolic processes are amenable to heparin in gelatin therapy: Deep venous thrombosis, thrombophlebitis, pulmonary embolism, post-ligation of the deep veins, and frostbite gangrene.

Repeated lumbar sympathetic blocks are useful adjuncts in the management of thrombophlebitis, but are unnecessary in the treatment of bland thrombosis.

Penicillin to prevent ensuing infection, papaverine, grains one, with atropine, grains 1/100 intravenously, and oxygen are valuable therapeutic aids to the problem of embolism and infarction.

Following venous ligation, heparin promotes the formation of collateral circulation, and prevents the development of thrombi proximal to the point of interruption.

Inasmuch as frostbite-gangrene is a thrombotic process occurring in the terminal venous and arterial channels, continuous heparinization for 10 to 14 days may prove very beneficial.

The general management of the patient with thrombosis varies with the severity of the disease. It is always wise to elevate the affected leg on three or four pillows. Application of elastic bandages to both legs forces the superficial circulation through the deep channels and augments deep venous flow. By removing and reapplying these bandages each day, the legs can be examined, and the proper compression maintained.

Administration of heparin in gelatin for thrombosis must be continued for at least seven days and may be required for 12 days or more. The patient is allowed out of bed three to four days after the disappearance of tenderness and fever, but heparinization is maintained for at least two more days.

When the patient is allowed out of bed, he should be encouraged to walk. While he is in a chair, it is imperative that the legs be elevated to prevent dependent stagnation of the blood.

If no recurrence of symptoms is noted during ambulation, no further therapy is required and the patient is observed for one or two days before discharge.

For pulmonary embolism or infarction, a minimum of 14 days of treatment is mandatory. In cases where the primary pathology persists to prevent ambulation or promotes continued venous stasis, a recurrence of the thrombotic process is likely. Such patients require heparin in gelatin for at least three weeks followed by careful observation of the legs or preferably, venous ligation.

SUMMARY

Heparin in gelatin, a modification of Heparin-Pitkin's is advised for the treatment of thrombosis.

The average dose is 400 mgm. deposited in the deep subcutaneous tissue every other day. The dose may vary with the weight of the patient and the extensiveness of the thrombotic process.

A constant even increase in the coagulation time to a therapeutic level is maintained for forty-eight hours.

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Asthma Due to Bacterial Allergy: Identified by Tissue Culture and Treated by Desensitization

HERMANN BLATT, M. D., and FRANK A. NANTZ, M. D.

ASTHMA is a clinical syndrome with a varied etiology. The vast literature on this subject has been recently reviewed by Unger and Gordon.[1] Miller,[2] in discussing the physiological basis for the treatment of intractable asthma, states that the most common causes of asthma are allergy and infection. The term allergy, as originally defined by von Pirquet, means any state of altered reactivity. It is not sufficiently descriptive and should be avoided. Coca introduced the term atopy to represent those states of altered reactivity in which an antigen-antibody reaction can be demonstrated. This corresponds to true allergy as defined by Doerr. Atopic asthma is a classic syndrome which is well recognized.

We wish to discuss non-atopic or infectious asthma. Bacterial allergy is also beset with terminologic confusion. The term bacterial allergy should be limited to bacterial hypersensitivity of the so-called tuberculin type. We use the term bacterial hypersensitivity in this sense only. There are five fundamental differences between atopy and bacterial hypersensitivity. These differences are presented in Table I. Heretofore, the skin test was the only method available to distinguish between atopy and bacterial hypersensitivity. See skin reactivity in Table I. We have discarded the skin test because of its limitations and unreliability.

In the atopically sensitized individual the tissue cells and blood leucocytes are not killed "in vitro" when in contact with the allergen. In bacterial hypersensitivity such cells are killed by the specific allergen in high dilution. See Table I-(5). We have taken advantage of this

TABLE I

	Type of Hypersensitivity	
	Atopy	Bacterial
1. Allergen responsible	Usually plant or animal	Usually bacteria
2. Skin reactivity	Immediate	Delayed
3. Atopic reagin	Present	Absent
4. Method of passive transfer	Prausnitz-Kuestner	Urbach-Koenigstein
5. Effect of allergen on tissue cells 'in vitro'	None	Necrosis

fact to devise a tissue culture test for bacterial hypersensitivity. This test was first described in the Annals of Allergy in 1947.[3] Blood leucocytes separated from plasma and cultured in fibrin

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are incubated in contact with various bacterial filtrates. If the slide cultures are necrotic the test is positive, and if viable the test is negative. As many as forty tests may be performed using only five cc. of blood. With this technique we have tested a group of non-atopic asthmatics to each of the following bacterial strains:

streptococcus, hemolytic, Group A (Lancefield)—30 strains	
streptococcus viridans	9 strains
staphlococcus aureus	10 strains
staphlococcus albus	7 strains
pneumococcus	types 1, 2, 3, 4, 5, 7, and 14
neisseria gonorrhea	1 strain
neisseria catarrhalis	1 strain
neisseria flavus	1 strain
neisseria sicca	1 strain
mycobacterium human	1 strain
mycobacterium bovine	1 strain
hemophilus pertussis	1 strain
hemophilus influenza	1 strain
hemophilus Ducreyi	1 strain
escherichia coli	2 strains
escherichia proteus	1 strain
escherichia alcalescens	1 strain
aerobacter aerogenes	1 strain
aerobacter cloacae	1 strain
shigella alcalescens	1 strain
shigella ceylonensis	1 strain
shigella ambigua	1 strain
shigella dysenteriae	1 strain
shigella Sonnei	1 strain
shigella paradysenteriae	V, W, X, Y, and Z
salmonella paratyphosa	3 strains
brucella abortus	1 strain
brucella suis	1 strain
brucella melitensis	1 strain
klebsiella pneumoniae	1 strain
pasteurella tularense	1 strain
eberthella typhosa	1 strain
pseudomonas aeruginosa	1 strain

CASE HISTORIES

Two typical case histories are presented. These cases have been selected from 17 private patients with bacterial asthma now under our care. In all of these cases no other physical or drug therapy is given while the desensitization program is being carried out, so that whatever improvement shown may not be ascribed to some other part of the treatment. A separate tuberculin syringe is selected and kept for each in-

dividual patient. Both the syringe and its needle are carefully washed in triple distilled water to avoid the danger of pyrogens in ordinary distilled water.

Case 1. W. M. was a 10-year-old white male who was first examined in June, 1938. He complained of asthma following an upper respiratory infection three weeks previously. He had had the usual childhood diseases without complications or sequelae. As a small child he had recurrent bouts of fever of unknown etiology. His allergic history was negative. There was no family history of allergy.

Physical examination in June, 1938, was not remarkable. His habitus was asthenic. There were enlarged cervical glands and diffuse wheezing throughout the chest. Laboratory studies were negative. In January, 1940, he had an attack of lobar pneumonia involving the left lower lobe. He also had a severe follicular tonsillitis. He immediately developed asthma and remained in status asthmaticus for several weeks. In February and March of that same year he had minor respiratory infections and each time he would suffer for a short period from asthma. In the interim between attacks of asthma he was symptom free.

In November, 1941, he developed a severe diffuse bronchitis which was again followed by asthma. When he recovered he was given a complete allergic survey which was entirely negative. The asthmatic attacks subsequently became more frequent. Originally his upper respiratory and asthmatic attacks occurred during the winter months. The wheezing increased and became constant throughout the year. He then moved to Arizona and California where his condition remained unchanged.

He returned to Cincinnati in 1947 and in October of that year he was hospitalized with status asthmaticus. He had been unable to work, and had lost twenty pounds during the previous two months. X-ray examination at this time showed increased broncho-vascular markings especially in the left lower lobe. Both diaphragms were depressed. The white count was 8000 with 8 per cent eosinophiles. All other laboratory studies were negative. He was given benadryl and pyribenzamine with no improvement. His allergic survey was repeated and was again negative.

The tissue culture test for bacterial hypersensitivity was done on three different occassions. He was tested against all of the bacteria previously listed. On all tests he was found to be positive to streptococcus viridans strains 1829 and 1585. He was negative to all other strains. We then undertook a program of specific desensitization. Sterile broth filtrates of these two strains were mixed and prepared in dilutions of 1:1,000,000, 1:100,000, 1:10,000, 1:1,000, 1:100, and 1:10. He was skin tested to 0.05 cc. of 1:1,000,000 dilution which was negative. Every three to four days he was injected subcutaneously with increasing doses. Each injection was increased by 0.1 cc. until 0.9 cc. of a given dilution was reached. The next lower dilution was then used beginning with 0.1 cc. and increasing in the same manner. There were two focal reactions in which his asthma definitely flared. Both reactions occurred with increasing doses of the 1:1,000,000 dilution. When reactions occurred the same dose was repeated until well tolerated. He is now being maintained on the 1:10 dilution.

In November, 1948, he was thoroughly reevaluated. He stated that for the first time in years he was free of asthma. He had not wheezed for two months. He has had no colds which usually start every fall. Chest examination was entirely clear. The white count was 6200 with no eosinophiles. Corrected sedimentation rate was plus ten. He had gained five pounds in the past six weeks. Tissue culture studies were repeated which were now negative to streptococcus strains 1829 and 1585 in dilution of 1:1000. Although symptom free at the present time, it is too early to evaluate the permanency of the specific desensitization.

* * *

Case 2. J. H. was a 21-year-old white female who was first examined in December, 1947. She gave a history of intractable asthma since childhood. Originally her attacks seemed to be precipitated by upper respiratory infections. For several years, however, her asthmatic symptoms have been more or less continuous. She travelled throughout the country finding no relief. She was subject to colds which always aggravated her asthma. She had two pregnancies with no effect upon her wheezing. Her mother has always had asthma, otherwise the family history was negative.

Physical examination in December, 1947, revealed an underweight asthenic individual with rales throughout the chest. X-ray of the chest showed increased hilar shadows bilaterally, the diaphragms were slightly depressed with limitation of movement under fluoroscopy. Corrected sedimentation rate was plus 40. Temperature was 99:0. The white count was 9600 with a normal differential. There were no eosinophiles in either the blood, sputum or nasal secretion. The remainder of the physical examination was normal. A complete allergic survey conducted in the usual manner with scratch and intracutaneous testing was entirely negative. Trial elimination diets were tried without benefit. Anti-histamine therapy also was prescribed without effect.

The tissue culture test for bacterial hypersensitivity was done on three different occasions.

She was found to be always positive to three strains, hemolytic streptococcus Group A (Lancefield) 9894, streptococcus viridans 1820, and staphlococcus albus 1315. Sterile broth filtrates of these three strains were mixed and prepared in dilutions of 1:1,000,000, 1:100,000, 1:10,000, 1:1000, 1:100, and 1:10. The patient was skin tested to 0.05 cc. of the 1:1,000,000 dilution without reaction. Subcutaneous desensitization was undertaken as previously described. The same tuberculin syringe was used each time and both syringe and needle were carefully washed in triple distilled water. This is necessary to avoid the effect of pyrogens in ordinary distilled water. She has now reached 1:10 dilution which is being continued as a maintenance dose. She had four focal reactions in which her asthma definitely flared. All of these reactions were brief and occurred with the higher dilutions. She has been symptom free for the past three months. Examination of her chest is entirely negative. The corrected sedimentation rate is plus 25 and she has gained six pounds in the past two months. It is of course too early to evaluate the permanency of this clinical improvement.

CONCLUSION

In conclusion, the report of these cases of asthma due to specific bacterial hyspersensitivity is presented. These cases illustrate the clinical application of a new method which the authors have been studying for a considerable time. It is designed to use tisssue culture as a means of identifying the bacteria involved and the consequent use of specific desensitization in the treatment. As a preliminary report, no claims are made other than that the methods have diagnostic value and apparently therapeutic value also although time alone can tell how much.

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Aspects of Sterility

The part that diet, as well as undue physical and mental stress, may play in the problem of sterility has been far better understood since the Germans first described Krieg's amenorrheas of World War I. Coghlan of Australia has shown that only 30 per cent of the returning soldiers from the Middle East have any chance of becoming fathers. General examination did not account for any of the low sperm counts. Since the end of World War II, he continues to get low counts in most returning men and war prisoners.—M. James Whitelaw, M. D., Phoenix, Ariz., Arizona Medicine, Vol. 5, No. 6, November, 1948.

KEEPING UP WITH MEDICINE

• THE cardiovascular system, the autonomic nervous system, and the kidney are always interdependent and should be considered as a group in renal malfunction or injury.

* * *

• ORNAMENTS may cause dermatitis.

* * *

• ASTHMA may be produced in aspirin-sensitive patients by benedryl (each of the drugs contain a coal tar radical).

* * *

• DO NOT forget that the fluxes used in soldering jewelry sometimes contain fluorides and zinc chlorides.

* * *

• THE renal handling of sodium and water may play a role in "essential" hypertension.

* * *

• CRUDE liver extract has been of temporary value in the treatment of acute and subacute lupus erythematosus.

* * *

• EVERY case of undiagnosed gross hematuria should become a surgical emergency insofar as a cystoscopic and pyelographic checkup is concerned.

* * *

• THE investigation of the cause of sterility in a barren wife should not be undertaken unless the husband will cooperate and submit himself for examination also, because the husband will contribute factors toward the causes of sterility in up to 60 per cent of cases.

* * *

• IODIDES orally remain especially valuable in the care of patients with vasomotor rhinitis whose primary complaints are referrable to inspissated mucous in the nasopharynx.

* * *

• PSYCHONEUROSIS is an old medical commodity repackaged and brightly relabeled and spotlighted.

* * *

• THERE is a commenable tendency to decrease the number of Schick tests in sensitized persons.

* * *

• A MIGRAINOUS type of headache may be noted in many types of intracranial disease.

* * *

• THE liver stores the cholesterol derived from food and combines it with fatty acids to form cholesterol estrus which help the transportation of fat throughout the body.—J. F.

New Developments in the Treatment of Cancer

JOSEPH L. DeCOURCY, M.D.

AS all of us know, in recent years the investigations of the enormous and extremely complicated mysteries of cancer have been multiplying. Now, at last, every conceivable phase of causation, diagnosis, and treatment is being studied. Moreover, even the possibilities of prevention are receiving attention in numerous experiments on animals. Discoveries are being made in every field.

In the field of causation, the number of known agents which may incite the growth of cancer is increasing remarkably. These agents are physical, chemical, and biologic. Among the physical factors which may initiate the growth of cancer are, of course, trauma, cold, heat, X-rays, gamma rays, radioactive elements, and ultra-violet rays. Many new physical agents are being produced in atomic research. These are man-made radioactive elements and powerful new rays, such as beams of high-speed electrons or fast neutrons.

CARCINOGENS

The chemicals agents which are carcinogenic are being determined at what may be called a surprising rate. The list of such cancer-causing chemicals includes many inorganic substances as well as organic compounds—for example, hydrocarbons, hormones, and other familiar metabolites —perhaps even cholesterol. Cholesterol, which is present in every tisssue, seems to act as a slow carcinogen under certain conditions in experimental animals. It is noteworthy that cholesterol-rich extracts from human tissues all contain small quantities of some unknown carcinogen.

Here we may take note that, as discoveries pile up in research on cancer-causation, the mystery grows deeper. The great problem is: What is the significance of the fact that many hundreds of different chemical agents can be used, under certain conditions, to cause cancer? Many of these agents are of normal metabolic origin. Just how and just when does a hormone, such as an estrogen, become carcinogenic? It would appear that, in order to answer this question, we must focus our attention upon the metabolic conditions within the susceptible individual. Consequently, we again become involved in the analysis of innumerable factors—not only complex in their relationships but also dynamic or ever-changing.

These innumerable metabolic factors are of course affected by the genetic constitution of the individual. We must somehow take into account the chromosomes and their constituent genes. We must take into account also the capacity of tissues to regulate cellular growth and to restrain such proliferation within normal limits. Cellular growth is affected by genetic constitution or hereditary factors, by metabolic conditions and by environmental factors to which the tissues are exposed.

In other words, the nature of the fundamental mechanism of the malignant transformation seemingly remains as obscure as ever—in spite of the discovery of more and more ways of causing cancer experimentally. Indeed, today, the mystery of cancer causation appears to be more complex and baffling than ever.

Nevertheless, from studies of cancer causation have come what may turn out to be the actual beginning of a true science of chemotherapy for cancer. Investigations of chemical agents somehow involved in the causation of cancer have suggested the trial of the same or closely related agents in the treatment of cancer.

SEX HORMONES

For instance, animal experiments demonstrated that the sex hormones are factors in the genesis and development of mammary cancer. These studies showed that the female sex hormones, especially the estrogens, can be used to induce mammary cancer in mice and other laboratory animals. It was also found that ovariectomy results in a marked reduction in the incidence of spontaneous mammary cancer. Furthermore, ovariectomy retards the development of such tumors in mice having a high susceptibility to the disease. Next, the question naturally arose: Cannot a sort of biochemical castration be effected by the administration of androgens? Would such biochemical castration be as effective as removal of the ovaries? Experimentation established that androgens may significantly reduce the incidence of spontaneous breast cancer in female mice of a highly suspectible strain.

Results obtained in experiments on animals were cautiously extended to patients especially those with advanced cancer of the breast. Years ago it was established that such patients may

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be markedly benefited by surgical or radiation castration. These beneficial effects have been confined almost exclusively to premenopausal patients. In some 15 to 30 per cent of premenopausal patients with advanced, recurrent or metastatic cancer of the breast, the response to castration is favorable. Pain is relieved. The physical status improves. Hemopoiesis is increased. The osseous metastases may apparently undergo regression. The beneficial effects are transitory, however, and no cure can be effected by this procedure.

Functional castration by administration of androgens to premenopausal patients with varying degrees of metastatic breast cancer has brought about dramatic if only temporary improvement, in perhaps 15 per cent of cases. Relief of pain and gain in weight may be remarkable. Previously decalcified areas of osseous metastases may undergo irregularly demonstrable calcification. The hormone, however must be administered in doses adequate to cause masculinization. Usually, testosterone propionate in oil is the preparation administered by injection. In some patients there may be a dangerous elevation of the blood calcium. Generally, the soft tissue disease is not affected. And it is to be noted that the great majority of patients are not benefited at all. Finally, even in the patients who do manifest an initial favorable response, the disease process becomes reactivated within a few months in most instances—although in some the progress of the disease may apparently be retarded for a few years.

ESTROGENS

In elderly women with advanced, recurrent or metastatic breast cancer, estrogenically active substances have been found beneficial—also in about 15 per cent of cases. In contrast with the results of androgen administration, the favorable influence of estrogens in selected patients is chiefly upon the soft tissue disease. Tumor masses may regress markedly. Ulceration of the primary tumor may decrease in size and, although rarely, may become epithelialized. Lymph node metastases may undergo some regression. Appetite and weight may increase, and the general physical condition of the patient may be decidedly improved. Still, the total effect is but palliation.

Palliation likewise follows the administration of diethylstilbestrol in cases of carcinoma of the prostate. Again, it is to be emphasized, the effect is but temporary. Deprivation or administration of sex hormone does not bring about a cure, whether in cancer of the breast or of the prostate. In cases which are operable, there is no substitute for radical surgery.

A great many patients, however, do not reach the specialist until only palliative measures remain. Development of new methods of palliation therefore represents true progress in therapy. Relief of pain may be temporary. Life may be prolonged but slightly. Yet these benefits are clearly worth while.

Far more significant and inspiring is the fact: Sex hormones do alter the course of advanced cancer of the breast or of the prostate. Just how a given hormone affects the disease process is unknown. It is known that androgens have the capacity to inhibit the gonadotropic activity of the pituitary gland; thus they may suppress ovarian activity—and provide biochemical or functional castration. Further, androgens are involved in protein metabolism and in osteogenesis. Such activities may be found to have basic meaning in the problem. Explanation of the effect of these hormones on special types of cancer would appear difficult. Their effects are variable, transitory and at times harmful. Administration of hormone is followed in some cases by acceleration of the disease process.

NITROGEN MUSTARDS

There are other developments which indicate that we are making some progress toward chemotherapy of cancer. The nitrogen mustards and urethane have recently been tried in leukemia as well as Hodgkin's disease and in cancer of the lung, melanoma and tumors of the central nervous system. The chemical structure of the nitrogen mustards is similar to that of mustard gas used in warfare. In the nitrogen mustards, however, the element nitrogen replaces the sulfur of mustard gas. The biologic effects of the nitrogen mustards are comparable to those of X-rays and gamma rays. In World War I it was established that mustard gas has an injurious effect on hemopoietic tissue. During World War II the nitrogen mustards were found to cause similar injury. It has been shown that nitrogen mustard therapy is almost invariably followed by a decrease in leukocyte count with lymphocytopenia and granulocytopenia, and often also by a decrease in red cells and platelets. In Hodgkin's disease, remissions lasting about a month are obtained in the great majority of cases. In myeloid leukemia, the early and moderately advanced stages respond well, but the remissions generally are shorter in duration then after roentgen irradiation. Lymphosarcoma, lymphatic leukemia, and acute leukemia do not appear to be influenced favorably. It has been reported that some response is obtained in melanoma and tumors of the central nervous system. Temporary regression of lung cancer results from nitrogen mustard therapy in about 50 per cent of cases; yet the end effect is practically insignificant. Most patients receiving this form of therapy manifest toxic reactions, especially nausea and vomiting. Investigators believe that nitrogen mustards may prove to be as valuable as roentgen irradiation in many cases

of leukemia. Research in progress may indicate additional application in the clinic. Although these compounds are not curative in any sense, they are regarded as chemotherapeutic agents having a place in the armamentarium of the clinician.

ROENTGEN IRRADIATION

The agent of choice in the treatment of leukemia still appears to be roentgen irradiation. Although it prolongs life but slightly, the patient is made more comfortable. In leukemia without any treatment, the average length of life is about 3 years. With roentgen therapy the average is 3.5 years. Recent studies show that radioactive phosphorus, radioactive gold and radioactive manganese are effective in the palliative treatment of this disease. In leukemia treated with radioactive phosphorus, the average length of life is about 3.6 years. There may be unfavorable late results of such therapy, however. The radioactive element is effective, of course, because it provides irradiation similar to roentgen rays. This radiation continues for a long time within the body. The possible ill effects are still undetermined. It is to be noted that radioactive elements are to be considered physicochemical therapeutic agents, with the emphasis on the physical rather than on the chemical effects. The radiation is a physical phenomenon, and provides the therapeutic effect. The place of the element in the periodic table—that is, the chemistry of the element—determines its localization within the body.

As regards radioactive iodine in the treatment of thyroid cancer, the consensus at this time is that the new agent has proved disappointing. The uptake of iodine by the less differentiated tumors of this gland is low. In fact, only about 15 per cent of thyroid cancers have been found to show detectable deposition of the radioactive element. To be sure, it may eventually be possible to devise some means of increasing the uptake of radioactive iodine by thyroid tumors.

There are already some indications that the radiation delivered by radioactive isotopes can be directed, at least to some extent. For example, it has just been reported that when radioactive zirconium is administered in colloid of large particle size, deposits of the radioactive elements are formed primarily in the liver and spleen. When given in colloid of small particle size, the radio-element is deposited chiefly in bone marrow and spleen. That is, the radioactive deposit can be directed primarily toward the liver or toward bone marrow, according to the size of the colloidal particles.

Last April in Washington, David Lilienthal, Chairman of the Atomic Energy Commission, announced the quantity production of an excellent and inexpensive substitute for radium, for use in the treatment of cancer. This substitute is radioactive cobalt. In its production, the metallic element, cobalt, is baked in a uranium pile at the Oak Ridge Laboratory. Cobalt, in natural form, is not radioactive. It becomes radioactive when subjected to bombardment by the powerful rays and streams of electric particles in the uranium pile. Cobalt is plentiful and cheap. In fact, Chairman Lilienthal calls the new product a "virtually costless metal" and has stated that the Atomic Energy Commission "is considering putting no price tag on it at all." In contrast, radioactive phosphorous and radioactive iodine are expensive and unavailable to most clinics.

RADIUM

Radium, of course, slowly loses its radioactivity, one half the mass of radium undergoing disintegration in about 1,590 years. That is, the half-life period of radium is almost 1,600 years, and that of radioactive cobalt is only 5.3 years. Nevertheless, this substitute for radium is so cheap that replacement of the active material will be a practically insignificant problem.

Like radium, radioactive cobalt gives off deeply penetrating gamma rays—which are, or course, similar to X-rays. As might be expected the gamma rays from radioactive cobalt have about the same effect on cancer cells as do the gamma rays emitted by radium. Consequently, radioactive cobalt presumably can be used wherever radium therapy is indicated. Although radium emits alpha particles—which are electrically charged helium nuclei—the new radioactive cobalt does not. Hence it may be found that this new therapeutic agent is somewhat safer to handle than radium, and clinicians may use it with less risk of after-effects. It must be remembered, however, that gamma rays—like X-rays—not only are effective in the treatment of certain tumors but also may, under certain conditions, cause cancer. Therefore it is not to be assumed that radioactive cobalt, as a substitute for radium, provides a new order of safety. The very cheapness of the new agent could conceivably lead to over-enthusiasm in its use. On the other hand, the factors of cost as well as the decidedly inadequate supply of radium have prevented a great many patients from gaining the benefits of therapy with this agent. The quantity production of radioactive cobalt must be regarded as a great practical step forward in the treatment of cancer, but only because the known techniques can now be applied on a wider scale. Neither therapeutic knowledge nor chemotherapy of cancer has advanced. The biologic effects of radium and radioactive cobalt result from a physical phenomenon, the emission of gamma radiation.

NEW AGENTS

As yet there is definitely no new agent which can be expected to replace or improve upon sur-

gical excision and radiologic therapy for human cancer. Yet the beginnings of true chemotherapy appear to have been made. Substances that bring about at least some favorable response, however limited and irregular, have been introduced into clinical practice. Besides sex hormones, nitrogen mustards, and urethane (whose action is somewhat similar to that of the nitrogen mustards), hundreds of different chemicals, tissue extracts, antiserums and antibiotics are being tested. Injections of extracts of human spleen and liver have been reported to have favorable effects upon some epidermal cancers. Beef and lamb liver extracts also have been found to have some apparently beneficial influence on such cancers. Work is now in progress with extracts from a number of other organs.

The effects of various antibiotics are being determined in experiments on animals and cultures of cancerous tissue. Extracts made from cultures in which penicillin is produced have been reported to contain still unknown substances which have the capacity to reduce the viability and inhibit the growth of several types of cancer tissue. A special polysaccharide from Bacillus prodigiosus has been found so effective in laboratory cultures of cancer tissue and in animal cancer that it is now being cautiously tested on cancer patients.

Successful use of synthetics related to folic acid has been recorded by a number of workers. Although the results were variable and evanescent, attempts to discover effective chemotherapeutic agents for cancer in man have taken this new direction. Enzymes and enzyme inhibitors are being tested by the score.

In all this work with chemicals and biochemicals, the successes with hormones and nitrogen mustards, however limited, are serving as inspiration. Investigators look forward hopefully to the possibility of somehow magnifying in a practicable manner the generally minor effects of substances already known to be at least slightly active in retarding the progress of human cancer. The new mass attack on cancer seeks to establish the foundations upon which a real science of chemotherapy can be ultimately established. While attempts are being made to establish this field, noteworthy progress is being made along surgical lines. Surgical techniques are being refined steadily. Preoperative and postoperative care is being improved. New anesthetics and analgesics are being tested and introduced. "Metapon", a new pain killing derivative of morphine, almost devoid of emetic effect, is more effective than morphine as an analgesic

In surgery itself, the tendency is toward more radical measures. This tendency is most clearly seen in the treatment of cancer of the oral cavity and upper respiratory tract. When competent operators undertake bold measures, in an encouraging percentage of cases a cure rather than mere palliation may be the result. In surgery of abdominal cancer there have been reported an increasing number of successes following remarkably extensive operative procedures. In some clinics it is now the policy to make at least an attempt to remove locally invasive disease which would be regarded as inoperable according to ordinary standards. The cure rates obtained are impressively high. Most patients thus helped have had considerable local extension of the primary cancer without blood-borne metastases.

The cure rate for all types of cancer will of course rise as diagnosis is improved and established earlier. Chemical tests, blood tests, tests for various substances in urine, new smear techniques and other diagnostic methods are under intensive investigation. The need for new diagnostic methods is great. As we all know, many times malignancy escapes detection until it is too late. Ignorance or procrastination on the part of the patient is frequently to blame. The extension of regular health examinations would do much to advance cancer control, by helping to establish diagnosis in the early stages.

WARFARE AGAINST CANCER

As the warfare against cancer is waged with increasing determination and as research advances along different lines, we can look forward hopefully to the future. Already we see what appear to be the beginnings of chemotherapy. Already the results obtained with sex hormones, nitrogen mustards, and urethane would seem to have rendered obsolete the classic conception of the autonomy of cancer cells. That is, cancer cells are not entirely unaffected by changing the concentration of a substance of metabolic origin, such as a sex hormone. In some instances, the effects of such hormonal alteration are dramatic even if temporary. The cancerous growth is affected—as it may be also by a nitrogen mustard or urethane, which are not metabolites but which cause metabolic changes within the patient. We see that there are indeed biochemical and pharmacological means of attacking malignant tumors. If limited research has brought to light so vital a fact, then widening and intensifying research should discover whole systems of chemicals and biochemicals whose effectiveness ascends from a low level to a high level—perhaps even to a plane on which definite cures are obtainable. Certainly we know that the investigators who seek drugs which will have markedly favorable effects on cancers of different types are not mere dreamers. Their investigations are at last guided by observations made in the clinic as well as by brilliant findings attained in experimentation on animals. Chemotherapy for cancer is probably in the process of being born.

Homologous Serum Jaundice: A Case Report

ARTHUR C. HEMPHILL, M.D., and THOMAS D. KINNEY, M.D.

ON the evening of November 17, 1947, L.B., a 57-year-old colored male, was admitted to the medical service of Cleveland City Hospital in a comatose state. On September 2, 1947, the patient entered another hospital complaining of swelling of the upper portion of the left lower leg. X-rays showed an osteolytic lesion involving the head of the fibula. A smaller, similar lesion was later seen in X-rays taken on the left elbow. Two days later the head of the fibula was removed and pathological examination revealed a plasma cell myeloma. He received one unit of double strength plasma and 250 cc. of regular plasma during and immediately following this operation. The patient developed ischemic necrosis of the left foot and on September 18, 1947, a mid-thigh amputation was done. During the operation he received 500 cc. of compatible type O, Rh positive whole blood and one unit of plasma. His postoperative course was uneventful and he was discharged on October 16, 1947. According to his wife he had remained in good health until one week before the present admission when he developed what was thought to be an upper respiratory infection with a cough productive of white frothy sputum, together with fever, a shaking chill and increased perspiration. For three days he complained of vague abdominal distress, headache, nausea and vomiting, generalized body aching and dull chest pain. These symptoms were gradually subsiding but 18 hours before admission he suddenly became irrational and lapsed into stupor.

The past history revealed no instance of exposure to any person with similar symptoms or jaundice.

Physical examination: The temperature was 36.3 degrees C., pulse was 100/min., respirations 28/min., and blood pressure 136/84. The patient was a well-developed and nourished male Negro who was comatose. The sclerae were deep yellow and funduscopic examination revealed grade II retinopathy with normal discs. The remainder of the examination was negative except for a well-healed low mid-thigh amputation on the left.

Laboratory findings: The urine was negative except for a 2 plus albumin. The hemoglobin was 15 grams, the red blood cell count was 4,700,000 and the white blood cell count 9,500 per cubic millimeter. The differential count was normal. The blood urea nitrogen was 47.6 milligrams per 100 cc. Clear spinal fluid was obtained from lumbar puncture and the pressure and dynamics were normal.

The patient remained comatose and died twenty hours after admission.

POSTMORTEM EXAMINATION

The body was that of a well-developed, well-nourished colored male. The sclerea were intensely yellow. There was a well-healed low mid-thigh amputation scar. The body fat and serosal surfaces had an icteric tinge. The liver weighed 950 grams and was small and shrunken and the capsule was finely wrinkled and dull. The parenchyma was soft and flabby and on section was orange brown mottled with yellow. The normal lobular pattern could not be discerned. The gallbladder contained light gray brown mucous instead of bile, and the extra hepatic biliary passages were patent throughout. The thyroid gland was palpably enlarged and section revealed several colloid adenomas, some with old hemorrhages and calcification. The lungs were increased in weight and there were foci of patchy consolidation in all lobes. There were petechiae in the epicardial fat and in the omentum and mesentery. The right testicle was smaller than the left and fibrous tissue was increased. The remainder of the organs were not remarkable. Permission was not granted for examination of the elbow.

Microscopic examination: No intact hepatic cords could be demonstrated in sections of the liver. The majority of the liver cells were poorly defined with granular cytoplasm which in some cells was vacuolated. The cytoplasm of other cells was completely absent. The nuclei of those remaining hepatic cells stained poorly with hematoxylin. In the central zones lakes of red blood cells were present. The perilobular stroma was distorted as were many of the portal triads. The bile ducts were lined by necrotic cells which had broken borders and pyknotic nuclei. No distinct collection of lymphocytes was seen in these regions, but scattered throughout the entire hepatic parenchyma an occasional polymorphonuclear leucocyte was noted. The striking feature of the liver sections was the slight degree of leucocytic infiltration in the presence of the extensive parenchymal destruction. The sections included the capsule which was wavy and substantiated the gross appearance of wrinkling. There were a few red blood cells and fibrin strands on the peritoneal surface of the capsule. The postmortem icterus index was 130; however, the specimen was slightly hemolized.

DISCUSSION

The clinical picture, the history of recent plasma administration, the period of time between the time of receiving the plasma and the onset of symptoms and the findings in the liver of this patient were consistent with a diagnosis of homologous serum jaundice. This patient received the equivalent of 1750 cc. of pooled plasma and 500 cc. of whole blood over a period of 53 to 67 days before the onset of the symptoms of his last illness. This is well within the incubation period of 40 to 180 days which is usually given for the disease.

The plasma had been prepared by the American Red Cross, and, unfortunately, adequate records of the units which this patient had received were not kept. Therefore no information

Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at Cleveland City Hospital as the 40th of a series of cases to be published under the heading of "Case Reports Presenting Clinical Problems."

as to the donors included in the pool or pools could be obtained. However, it is assumed that the plasma pools were the usual ones made up of the plasma of 15 to 20 donors.

The unit of whole blood which was given to this patient had been donated by a 27-year-old white male. He had never been jaundiced and was unable to describe any symptoms which might have been due to mild or subclinical hepatitis. He had been an officer in the Air Force and early in 1942 had received inoculations for both the Pacific and African theaters of war. Although he had remained well, many men in his unit had had acute hepatitis after innoculation with yellow fever vaccine. At this time the vaccine used was made with human serum, but it is impossible to state that the vaccine used for his innoculation contained the icterogenic agent.

Although the possibility that the causative agent was transferred through the medium of the whole blood transfusion cannot be eliminated, it is more likely that a portion of the plasma which the patient had received was at fault. Spurling, Shone and Vaughn[1] have shown that the incidence of homologous serum jaundice following whole blood transfusion alone is extremely uncommon. Corroborative findings were noted by Louitt and Maunsell[2] and Grossman and Saward.[3]

On the other hand, the patient received 7 units of plasma and since it is possible that each unit came from a separate pool, and since each pool was made up of plasma collected from 15 to 20 donors, the mathematical possibility exists of the plasma administered being contaminated by an icterogenic agent of any one of 105 to 140 donors.

Over the period of the past twelve to fifteen years a form of acute hepatitis which follows the administration of human blood or its products has been widely discussed in the literature. Although it does not differ from so-called acute epidemic hepatitis in the pathological findings, it has arbitrarily been given the name of homologous serum jaundice to differentiate it from those cases in which the route of infection is not known. Its incubation period is somewhat longer than that of epidemic hepatitis, and the disease is slightly more severe. The etiological agent has been identified as a virus. Typically, homologous serum jaundice is characterized by nausea and vomiting, anorexia, malaise, vague abdominal distress, general body aching and sometimes chills, and an apparent upper respiratory infection in a patient who has received either whole blood or plasma 40 to 180 days previously. These symptoms are soon followed by increasing jaundice and apathy. Physical examination reveals jaundice and often varying degrees of tenderness over the liver. The white blood cell count is usually somewhat decreased and liver function tests reveal hepatic impairment.

Since the cessation of the use of yellow fever vaccine prepared with human serum in 1942, the great majority of the reported cases have occurred in military personnel who had received whole blood or plasma. With the increasing use of these agents in civilian medicine, however, it is only natural that a certain number of cases must occur in civilian hospitals. The fact that only very small amounts of infected serum or plasma (0.001 to 0.01 cc.) can give rise to homologous serum jaundice makes it obvious that the real danger of causing a number of cases lies in contaminating plasma pools, portions of which may be given to any number of patients by including the plasma of an individual whose serum contains the infective agent.

Scheinberg, Kinney, and Janeway[4] have suggested several methods by which the incidence of homologous serum jaundice can be reduced Blood from any person who has ever had jaundice or hepatitis or who has been in contact with jaundice within the past year or who has received human blood or its products should not be utilized. Physical examination of each donor should be done to be sure that there is no fever or icterus, that the liver is neither enlarged nor tender, and that the spleen is not enlarged. In the processing laboratory the serum bilirubin of any unit of plasma which appears yellow should be determined and the unit discarded if the bilirubin level is elevated. Plasma pools should contain as few donors as reasonable and should be distributed among as few patients as feasible. Whenever possible whole blood and the products of plasma fractionation should be used rather than plasma.

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Hemoglobin Level in Old Age

The extension is in the direction of a greater hemoglobin content rather than less, as has been expected in the past. The range also appears to be less in women than in men. It is strange that the highest mean figures were found in the male patients of a chronic hospital, while the male senile dements also had a percentage above the normal adult level. It also suggests that the high hemoglobin levels of senile cases with pulmonary emphysema may need to be considered with a new eye.—Trevor H. Howell, Geriatrics, Vol. 3, No. 6, Nov.-Dec., 1948.

The Use of Streptomycin in Tuberculosis

INDICATIONS for Treatment: Nearly all forms of tuberculosis respond to treatment with streptomycin in some degree. However, the drug should by no means be used indiscriminately.

It is extremely difficult to lay down hard and fast rules for the use of streptomycin in pulmonary tuberculosis. Especial care in the selection of cases is necessary. The drug has its greatest usefulness in cases with an appreciable amount of exudative disease. In some other cases streptomycin is responsible for symptomatic improvement and the prevention of complications.

1. Definitive treatment: This category includes chiefly progressive lesions of recent origin with little or no destruction of tissue, such as progressive primary tuberculosis and tuberculosis due to hematogenic and bronchiogenic dissemination.

2. Preparation for surgical procedures, including temporary and permanent collapse and excisional surgery. In some cases pneumothorax can be instituted sooner and with greater safety after a course of streptomycin. Not infrequently the drug is of great value in preparing patients as candidates for thoracoplasty. As prophylaxis, streptomycin should be used routinely in excisional procedures.

It must be emphasized again and again that streptomycin is not a substitute for sanatorium care and other proven procedures. Rather it is a valuable adjunct to these other measures.

EXTRAPULMONARY TUBERCULOSIS

Streptomycin is the only treatment available in miliary tuberculosis and tuberculous meningitis. In such cases early and intensive treatment is imperative. Streptomycin is the treatment of choice for tuberculous sinuses, tuberculosis of the oropharynx, larynx and tracheobronchial tree, tuberculous enteritis and peritonitis, tuberculous otitis media, and tuberculous pericarditis. In renal tuberculosis, symptomatic improvement is usually prolonged and bacterial conversion occurs in some cases. Tuberculosis of the bones and joints is often improved by streptomycin but chemotherapy is not a substitute for orthopedic surgery when this is indicated.

Streptomycin is valuable as preoperative and postoperative treatment of tuberculosis in surgery of the genito-urinary tract, surgery of bones and joints, pericardiolysis, incision and drainage of abscesses and fistuectomy.

ADMINISTRATION

Streptomycin is administered by intramuscular or deep subcutaneous injection. The optimal regimen for the administration of streptomycin has not been determined. In most forms of tuberculosis results appear to be satisfactory when a dose of .5 to 1 gram a day is administered in one or two injections for six to eight weeks. With this mode of therapy complications are very infrequent and in most cases their clinical importance may be discounted. In tuberculous meningitis and miliary tuberculosis treatment should be vigorous; a dose as high as two grams per day for four months, or longer if necessary. In tuberculous meningitis results seemingly are better when intramuscular injection is supplemented by intrathecal injection of from 25 to 50 milligrams every twenty-four to forty-eight hours for two or three months, or as long as this method of administration is tolerated by the patient.

Since drug fastness is apparently closely related to duration of treatment, regardless of the daily dosage, limitation of the period to a few weeks may be effective in avoiding this phenomenon in many cases.

The physician handling a case of tuberculosis would do well to ask himself the following questions before administering streptomycin.

1. Why is streptomycin being used; for definitive therapy, as preparation for surgery, for prophylaxis, or for relief of distressing symptoms?

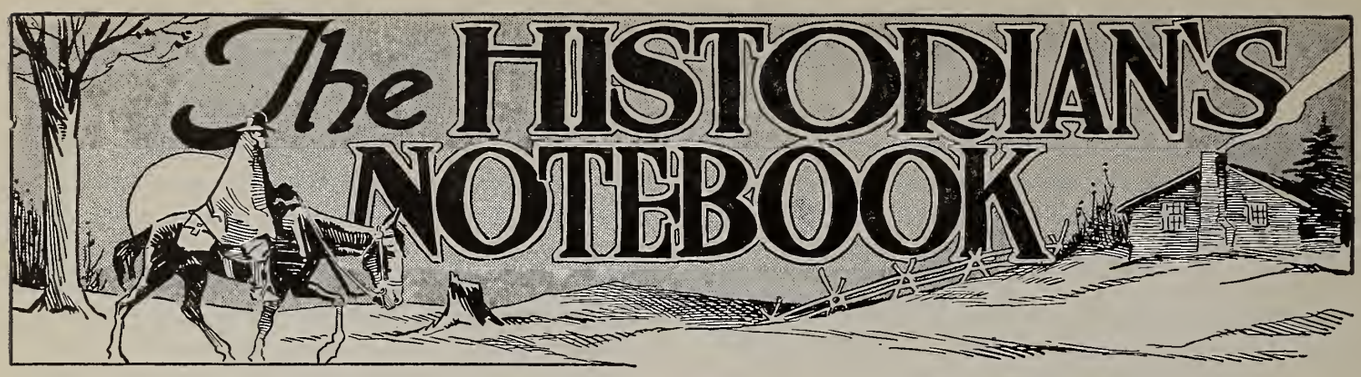
2. Is the type of lesion present of such a nature as to warrant the use of streptomycin in addition to other available therapy?

3. Can the purpose of chemotherapy be accomplished within the relatively short period of the drug's effectiveness? (Almost three-fourths of the patients show resistant organisms after three to four months of continuous daily streptomycin treatment.)

OTHER CHEMICAL AND ANTIBIOTIC SUBSTANCES

There is no other substance known today which compares with streptomycin in its effectiveness against tuberculosis. The sulfones, promin and promizole, are generally ineffective alone. Experimental work is in process to determine whether or not there is synergistic action when any of these are added to streptomycin. Para-aminosalicylic acid is promising on the basis of laboratory experimentation but sufficient clinical work has not yet been done to permit evaluation of this drug. Subtilin has not had sufficient clinical trial and there is not yet enough animal experimentation to indicate its usefulness. Of the many other antibiotic substances, none has shown in preliminary experimentation indication of real value against tuberculosis and none has had clinical trial.

A Report by the Committee on Chemotherapy and Antibiotics of the American College of Chest Physicians. Submitted for publication October 4, 1948.



The First Physician's Telephones and the First Telephone Secretary in Columbus, 1879

CLARENCE A. SWOYER

ON June 2, 1875, in an attic in Boston, Prof. Alexander Graham Bell and Mr. Watson discovered the principle of the telephone and radio loud-speaker. A. Graham Bell's father and grandfather were professional speech experts, and from his very early youth he was surrounded with the problems of the deaf. Prior to 1866, he had no idea of improving communication among the people other than to improve the hearing of the deaf, no idea at all of ever discovering anything like a telephone. During the course of his later experimentation, however, the idea of a telephone did finally come to him. This is another fine example of the truth of Pasteur's declaration that in the field of observation great discoveries only come to the prepared mind.

Finally, on March 10, 1876, the first speech was transmitted electrically when Prof. Bell spilled dilute sulphuric acid on his trousers and made that historic call for help: "Mr. Watson, come here, I want you!" Thus came the great telephone systems of the world. Prof. Bell exhibited his invention at the Philadelphia Centennial exposition in the hope of interesting capital. In this he was very fortunate. As a result of this exhibition, Dom Pedro, Emperor of Brazil, who had the attention of the American public on account of his visit to the United States and to the Philadelphia Fair, could call to their attention the telephone of Prof. Bell as no one else at that time could have done.

Someday someone must write the story of the telephone and Columbus, for here we have one of the first cities to install a telephone system and being a typical American city, the growth of the city and its telephone system would be as representative of the subject as one could possibly find. When the story is told, it will have to come, not from a professional historian, but from an amateur historian—someone in The Telephone Pioneers of America. It is hoped that we will not have to wait too long, for the original telephone workers have past and the second generation is gone, also. It is just possible that the newly formed Franklin County Historical Society may furnish the impetus which will bring us this most valuable story.—Editor.

The Author

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Dom Pedro discovered Bell in an isolated corner of the Exposition Building. The Emperor had met Bell in connection with their mutual interest in the problems of the deaf. "What have you here," asked the Emperor of Bell. "I have a telephone; it talks," was Bell's reply.

Bell then gave Dom Pedro a demonstration. Dom Pedro threw up his hands and exclaimed, "My God, it talks." It was this utterance of the Emperor that really called the attention of the American people as well as that of the whole world to the fact that the telephone had been invented and that it really worked. Bell's heretofore obscure device and patent became one of the great things to be remembered about the Philadelphia Centennial Exposition.

In 1926, when the Bell Telephone System was celebrating the fiftieth anniversary of the invention of the telephone, one stock story came out at each of the dinners held throughout the country. The Bell System claimed for its own that first expression of Dom Pedro, "My God, it talks."

Many were the attainments of Dr. Bell during his life span of 75 years. A dozen honorary degrees were given him. One of these, Doctor of Medicine, Heidelberg, 1886, was in recognition of his development of the electric probe in connection with surgery.

It is interesting to note that within eighteen

months after its invention, the telephone was at work in the city of Columbus.

George H. Twiss and Francis C. Sessions established public telephone service with Bell instruments on January 1, 1879. Mr. Sessions owned the Sessions Block at High and Long Streets and it was but natural that the Exchange should be set up in this building, which site is now marked with an appropriate bronze tablet. Mr. Sessions apparently had the money invested in the project and Mr. Twiss his time for he was first manager. The Exchange has been described by those who worked in it as follows:

> "A bare, barn-like loft about 50 feet long and 25 feet wide, lighted by three windows at the eastern end which looked out on a narrow, dingy court and the windows were never washed and I doubt if the floors were ever scrubbed. We used to sweep them out ourselves.
>
> "The switchboard was over in one corner by the window so that the wires were brought in at the window easily. There was a three-quarter inch angur hole bored in the frame and all lines were brought through that one hole with annunciator wire—the paraffin taped wire with twisted covering. The switchboard was a shelf about eight inches wide and five feet long on which were mounted about twenty little diminuative Morse sounders. In behind each of these was a brass spring that contacted with the head of a screw and when we wanted to call a party we lifted that spring and used it as a Morse key to make a Code call for that party.
>
> "We had to devise a signal call for each customer. A good many of them simply had a Morse sounder in their station but some had a little tap bell.
>
> "When we would call them, they would answer with an acknowledgment in the Morse Code, then they would switch on their telephone. Using the instrument first as the receiver and then as the transmitter they would do their talking."

All things considered, it was little wonder that customers in their moments of aggravation were given to cussing the instrument. Young boys were hired to service the Exchange and not to be outdone by the customers, these youngsters would cuss right back at them. The owners of The Columbus Telephone Exchange soon realized that if this was to go on, the telephone would soon fall into disrepute. Consequently they began to look around for a young lady to take over the work and, merely by her presence, introduce some decorum into the service which the telephone offered.

It was for this purpose that Mr. Twiss and Mr. Sessions called upon Mrs. Julia Hodgkins to see if her daughter, Alice Belle, would not take this job. Alice Belle had just finished her grade school education and was now 16 years of age. So she consented to take the task for a trial period to see how it would work out. Alice Belle thus became, in October 1879, the first telephone girl in Columbus, the third in Ohio and one of the first in the nation.

Miss Hodgkins was paid $10.00 per month and worked from 7:00 in the morning until 5:30 in the afternoon with one hour off for lunch. But shortly, the manager had the services of three other young ladies at $10.00 per month and Miss Hodgkins was made chief operator and her salary raised to $17.50 per month.

The phones then were $1.25 a month. William D. Bresnahan was hired as night operator. It is told of this polite young Irishman that he usually raised his hat when talking to a lady over the phone. He received a monthly salary of $25.00.

In the meantime Dudley Fisher, the father of our well-known cartoonist and comic strip creator, had entered the Ohio State University as a student in 1878. There was at that time a telegraph line running from the telegraph office to the University. Young Fisher was living on High Street and was allowed to cut in a loop on this line. He had a Morse key, a sounder, and later a telephone receiver for talking after signaling by Morse code. In June, 1879, he went to work for the Telephone Company as the repairman, then known as the "Telephone Inspector."

Mr. Fisher worked a twelve-hour day to do whatever there was to do, from noon to four o'clock, and to operate the switchboard from four o'clock to midnight. We find him reminiscing:

> "The principal duty that I had during the evening was to play on my flute into the instruments so that the customers could hear music over the telephone. Well, if it were anything but the novelty of the telephone, they would not have considered it music but it served its purpose to teach the people how to use their telephone."[6]

Back in 1945, Johnny Jones ran an appeal in his column in *The Columbus Evening Dispatch* for old telephone directories and as a result it was learned that Mr. Charles Moore of 99 South Burgess Avenue in Columbus owned a copy of the second one issued. The first Directory had been issued in March, 1879. It was printed by Cott and Hann and listed 105 telephones in service. The classified section disclosed twenty different classes of businessmen having the service. No copy of this list is known to exist and these facts have been taken from a current issue of *The Columbus Evening Dispatch.* In the meantime, The Western Union Telegraph Company purchased the Columbus Telephone Exchange in July, and moved it to the fourth floor of the Jones Block, southeast corner of High and Long.

In the second Directory, issued December 1879 by the Western Union Company, we find five physicians listed:

> "Baldwin, Dr. J. A. (sic), 113 East Long St.
> Beckwith, Dr. E. C., 198 East Town St.
> Flowers, Dr. J. R., 82 East Town St.

Loving, Dr. S., 72 East Gap St.*
Kreosen, Dr. Jas. C., cor. Seventh and Long Sts."

Physicians are a curiously conservative lot and must have been quite slow to take up with this new contrivance. Then, too, the services that it offered were not great especially in the case of an emergency.

A better idea can be gained of this if we read the description by Miss Alice Belle Hodgkins (later Mrs. Alice Belle Hodgkins Martin of 1265 Pennsylvania Avenue, Columbus, Ohio, who died September 13, 1934, aged 71):

"Some very funny things happened in these days, one thing in particular. We had only one desk phone in the office and my work was to answer all calls coming in, the boys did the connecting. No numbers were needed then. A call would come in, "Hello, Central, Neil House wants the Depot." About 187 subscribers, very few lines, and all of them party lines and by signal, so when a call for the manager came in, he had to use my phone, a mere mouth piece and note this was not very pleasant to me as he was a constant smoker—you can guess the rest.

"Then when a fire alarm came in, perhaps the subscriber would be so confused that he would not wait for the Headquarters, but would leave the call with the operator. She would announce it aloud, calling the Fire Department then at the Third Street Headquarters. Where the Ruggery Building is now located, fifty years ago was the Gay Street Engine House. While the alarm was being phoned in from the Exchange to Headquarters, I would rap a heavy wire put up for that purpose running from the Gay Street Engine House up to the Exchange window and then I would call out a report of the fire. In those days the Department had horses. It was atime to see what house was the first to respond to the alarm and many times the alarm was given from our office by rapping on this wire. The firemen would rush to the sidewalk, place their hands back of their ears to catch the location. Meantime, the horses seemed to know what the sound on that wire meant and would come out of their stalls and take their places at once. And many times the firemen would be out and gone before the alarm was sounded at their own Engine House. They always appreciated it and expressed it by sending flowers and sweets up to the Exchange."

One of the earliest telephone users in Columbus was Dr. James Fairchild Baldwin. In those early days of the telephone, when Dr. Baldwin was out on a call, Miss Alice Belle Hodgkins would intercept his calls, taking the message and delivering them all upon Dr. Baldwin's return to his office, so that from the time Dr. Baldwin installed his first phone early in 1879 until his death on January 20, 1936, his whereabouts were always carefully covered by his telephone service. He was the first subscriber in Ohio to have a telephone for 57 continuous years and all in one city.

It was but natural that this progressive young physician, just around the corner at Fourth and Long Streets should arrange for this service. In later years, he took to the bicycle and the automobile just as promptly and put them to use in his practice, for his practice was his vocation and his avocation—his life.

Dr. Baldwin's mechanically inclined mind outwitted the Telephone Company, by having an unusually long cord attached to his telephone. In this way when his office hours were over in the basement of his home, he would place the instrument in his handy dumb waiter and send it up to the first or second floor of his home as the need might be. The Telephone Company protested this multiple use of this one instrument. But they lost the argument as he was permitted to keep the arrangement as long as he lived there.

In those days the service of the telephone company was intimate and friendly, very personal, as we can show by quoting again from Mr. Fisher:

"We never thought of calling by numbers; they always called by name; and it was a common thing to have Mr. Atcherson call up and say, 'Tell my wife I won't be home for dinner.' And I would call her up and he wouldn't have to tell me who he was nor who his wife was. I knew all about it. And sometimes he would call up and want to talk with his wife and I would say, 'Mrs. Atcherson is not at home, she went down to her sister's.' I knew what they were doing and planning to do and I told him. That was the way things were managed in those days."

A long list of the "firsts" of Dr. Baldwin have been recited: The removal of knife blade from the lung by operation; five ectopic pregnancies diagnosed and operated upon before rupture; recommendation that all appendices be routinely removed when the abdomen is opened for any reason; the Baldwin Operation for the construction of a vagina; the grafting operation for making an upper lip; and the largest retroperitoneal fibroid tumor to be removed successfully.

Dr. Baldwin had virtually no private life. Every waking hour and thought was devoted to his profession. Even as a young man and all through his life, he was ready for call at anytime in the day or night; and a telephone call, no matter at what time of the night or how far away, how severe the weather, would always have a prompt response on the part of Dr. Baldwin. No wonder he was among the first to welcome the telephone as well as the first to arrange for telephone secretarial service, as Johnny Jones insists we must now call the young ladies at the Medical Bureau who cover the whereabouts of Columbus physicians.

* The 1879 City Directory shows Dr. S. Loving at 72 East Gay Street.

Proceedings of The Council . . .

Action at A. M. A. Session Reviewed at Dec. 12 Meeting; Legislative Proposals Discussed and Referred to Committee; 1949 Budget Adopted

A REGULAR meeting of The Council of the Ohio State Medical Association was held on Sunday, December 12, 1948, in the State Headquarters Office, Columbus. All members of The Council were present except Doctors Bowman and Rutledge. Others attending the meeting were: Dr. Jonathan Forman, Editor of *The Journal*; Dr. C. C. Sherburne, Delegate to the A. M. A., Dr. H. M Platter, Secretary of the State Medical Board; and Secretaries Nelson, Saville, Page and Moore.

President Brindley emphasized the importance of close contacts between members of The Council and the county medical societies of their districts during the coming year because of important legislative and other issues which will arise.

On **motion** by Dr. Swartz, seconded by Dr. Messenger, and **carried,** the minutes of the special meeting of The Council held on November 14, 1948, **were approved.**

MEMBERSHIP STATISTICS

The Executive Secretary submitted a report on membership showing a total membership, as of December 10, 1948, of 7,328, the largest in the history of the Association; compared to a total membership of 7,106 as of December 31, 1947. Of the total membership, 24 are members through waiver of dues, being temporarily in military service.

On **motion** by Dr. Clodfelter, seconded by Dr. Swartz, and **carried,** The Council authorized continuance of the policy of waiving State Association dues during 1949 for physicians serving temporarily in the Armed Forces.

Members of The Council reported on visits to and contacts with their respective county medical societies.

REPORT ON A. M. A. MEETING

Dr. Lincke and Dr. Sherburne, two of Ohio's delegates to the American Medical Association, reported on the business transacted at the recent interim session of the American Medical Association House of Delegates at St. Louis. They reported on the action of the House of Delegates in refusing to approve a proposal for the organization of a Blue Cross-Blue Shield Association and a proposal for the organization of a Blue Cross-Blue Shield National Insurance Company; but called attention to the fact that the A. M. A. House of Delegates had endorsed the creation of a national Blue Cross-Blue Shield enrollment agency to assist state and local plans in enrolling the employees of large national industries.

LEVY OF ASSESSMENT ENDORSED

Special attention was called to the action of the House of Delegates of the American Medical Association in authorizing the Board of Trustees to levy a $25.00 assessment on all members of the American Medical Association for the purpose of carrying on a nation-wide health education program and public relations activities. In this connection the Executive Secretary read communications from the American Medical Association on this question.

On **motion** by Dr. Dixon, seconded by Dr. Lincke, and **carried,** The Council endorsed the action of the House of Delegates of the American Medical Association on the matter of the $25.00 assessment and offered the cooperation of the Ohio State Medical Association in the collection of the assessment; but at the same time instructed the President to communicate with Dr. George F. Lull, Secretary of the American Medical Association, and outline certain recommendations and suggestions on this matter for consideration by the Board of Trustees of the American Medical Association. In taking this action, The Council expressed the opinion that the collection of the $25.00 A. M. A. assessment should not be confused with the collection of State Association dues and that the customary procedure for the collection of State Association dues should be carried out by the Columbus Office.

1949 ANNUAL MEETING

Preliminary plans to date for the 1949 Annual Meeting in Columbus, April 19-22, inclusive, **were approved,** on **motion** by Dr. Mundy, seconded by Dr. Swett, and **carried.** This action specified that the House of Delegates should meet on Tuesday evening, April 19, 6:00 o'clock, and at 4:00 p m. on Thursday, April 21; and that the Thursday evening general session, at which economic, social and legislative questions will be discussed, should start at 8:30 o'clock.

LEGISLATIVE PROPOSALS REFERRED

The Executive Secretary reviewed a number of pieces of anticipated legislation which undoubtedly will be proposed to the Ohio General

Assembly convening in January. On motion by Dr. Lincke, seconded by Dr. Mundy, and carried, all of these questions were referred to the Committee on Public Relations and Economics for review and study and for a report back to The Council at its next meeting, which will be held on February 27, 1949, at which The Council will take definite action.

RURAL HEALTH REPORTS

A lengthy report from the Committee on Rural Health, regarding the establishment of medical scholarships, was reviewed; and on motion by Dr. Dixon, seconded by Dr. Davis, and carried, the report was recommitted to the committee with instructions to present definite recommendations at the next meeting of The Council.

A suggestion from the Committee on Rural Health, that the Ohio State Medical Association join with the Ohio State Veterinary Medical Association, Ohio State University Extension Service, Ohio Department of Health, and the Ohio Department of Agriculture in issuing a rural health newsletter periodically, was approved on motion by Dr. Mundy, seconded by Dr. Davis, and carried. The letter would be mailed to county agricultural agents, farm leaders, veterinarians, members of rural health committees of county medical societies and other interested persons.

MILITARY MANPOWER COMMITTEES

A communication from Major General R. W. Bliss, Surgeon General of the United States Army, asking for the cooperation of the Ohio State Medical Association and of the county medical societies of Ohio, was read and discussed. General Bliss pointed out that it is planned to establish a professional manpower subcommittee to the various Military Manpower Committees being organized in various communities, and that county medical societies will be requested to submit the names of several local physicians to serve on such subcommittees. Members of The Council expressed themselves as believing that each county medical society, on request, should see that there is proper medical representation on such committees when organized, primarily to see that any recruiting drives which are conducted would take into consideration the supply and demand of the local community with regard to medical personnel and to place the medical profession in a position in each community where it can offer suitable advice and counsel to the Military Manpower Committee. On motion by Dr. Davis, seconded by Dr. Swett, and carried, The Council authorized the Executive Secretary to inform each county medical society of this action by The Council and to suggest that each county medical society be prepared to name representatives on such a subcommittee, if requested to do so.

CHILD HEALTH REPORT

A request from Dr. Benjamin Hoyer, Cincinnati, chairman of the Ohio section of the American Academy of Pediatrics, requesting that a report of a child health survey of Ohio made by his organization be published in *The Ohio State Medical Journal* for the information of all physicians, was considered. On motion by Dr. Lincke, seconded by Dr. Hattery, and carried, the Editor of *The Journal* was instructed to publish the report with a proper explanatory note regarding the study and report. Other suggestions made by Dr. Hoyer regarding conclusions and recommendations and the formation of a special committee for this purpose were not acted upon at this time but left pending for future consideration.

DIABETES PROGRAM

A communication from the Stark County Medical Society, asking The Council to express an opinion regarding a proposed letter to be sent to the physicians of that county on the educational and detection program of the American Diabetes Association, was read and discussed. On motion by Dr. Lincke, seconded by Dr. Foster, and carried, The Council approved the text of the proposed letter.

PRESIDENTS-SECRETARIES CONFERENCE

There was a general discussion as to the proper time for the annual conference of presidents and secretaries of county medical societies. On motion by Dr. Davis, seconded by Dr. Clodfelter, and carried, it was decided to hold the conference on Sunday, March 20, in Columbus, providing suitable space can be arranged, and that the chairman of the county society legislative committees also be invited to attend.

REGARDING TELEPHONE LISTINGS

A communication from the Ohio Bell Telephone Company, asking for the opinion of the Ohio State Medical Association with respect to the sale of bold face listings for physicians in the white pages of future telephone directories was read and discussed. On motion by Dr. Lincke, seconded by Dr. Mundy, and carried, The Council instructed the Executive Secretary to advise the Ohio Bell Telephone Company that it felt that such a listing would be undesirable so far as the medical profession is concerned and would in effect be a violation of the principles of medical ethics on the part of any physician purchasing such a listing.

FINANCES AND BUDGET

The Council then went into executive session to consider a report of the Committee on Audit-

ing and Appropriations with respect to the finances of the Association and a proposed budget for the calendar year 1949. After an extensive discussion of the finances of the Association and careful consideration of the proposed budget, item by item, on **motion** by Dr. Swartz, seconded by Dr. Dixon, and **carried**, the report of the Committee, including the following budget for 1949, was **approved**:

BUDGET FOR 1949

The Ohio State Medical Journal	$20,000
Executive Secretary, Salary	10,000
Executive Secretary, Expense	1,500
Stenographic-Clerical Personnel	12,000
President, Expense	1,000
Council, Expense	2,500
A. M. A. Delegates, Expense	2,500
Department of Public Relations (see below)	33,600
Director, Salary	$8,500
Director, Expense	1,500
Asst. Director, Salary	4,800
Asst. Director, Expense	800
Exhibits and Newspaper Publicity	5,000
Literature	7,500
Postage and Supplies	2,000
Speakers' Bureau	1,000
Miscellaneous Expense	2,500
Committee on Education	300
Committee on Public Relations and Economics	500
Committee on Scientific Work	1,000
Committee on Auditing and Appropriations	200
Committee on Cancer	500
Committee on Industrial Health	500
Committee on Medical Care of Veterans	200
Committee on Medical Service Plans	200
Committee on National Emergency Medical Service	500
Postgraduate Programs	2,500
Committee on Rural Health	500
Committee on School Health	800
Miscellaneous Committees	200
Annual Meeting	15,000
Conference of County Society Presidents-Secretaries	1,500
Postage, Telephone, and Telegraph	2,500
Professional Relations Activities	4,500
Rent, Insurance, and Bonding	6,500
Stationery and Supplies	2,000
Employees' Retirement Fund	2,500
Permanent Reserve Fund	10,000
Contingent Unassigned	5,245

There being no further business, The Council adjourned to meet on Sunday, February 27, 1949, 9:30 a. m.

Attest: CHARLES S. NELSON,
Executive Secretary.

Proposed Amendment for Action By House of Delegates

At the 1949 Annual Meeting of the Ohio State Medical Association in Columbus, April 19-22, inclusive, the following proposed amendment to Chapter 8, Section 7, of the By-Laws of the Association will be voted upon by the House of Delegates:

"In Chapter 8, Section 7, of the By-Laws, relating to the filling of vacancies in office by The Council, delete the last sentence reading as follows: 'The appointee shall serve until his successor has been elected and qualified' and substitute in lieu thereof the following: 'The appointee shall serve until the next Annual Meeting of the House of Delegates at which time the office shall be filled as provided for in the Constitution and By-Laws.'"

This announcement is published for the information of the membership in compliance with the provision of the By-Laws requiring proposed amendments to be published in The Journal at least one month before the Annual Meeting.

Examinations in Obstetrics

The next written examination and review of case histories by the American Board of Obstetrics and Gynecology, Inc., (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, Feb. 4. Arrangements will be made as far as is possible for candidates to take the Part I examination at places convenient for them.

Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held May 8-14 at the Hotel Shoreland, Chicago. Further information may be obtained by writing the board at 1015 Highland Bldg., Pittsburgh 6, Pa.

With Your New Year's Resolutions



Make Hotel Reservations

for the

1949 ANNUAL MEETING

OHIO STATE MEDICAL ASSOCIATION

Columbus, Ohio — April 19 - 20 - 21 - 22

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
NEIL HOUSE, 35 So. High St. (Headquarters Hotel)	$4.00-7.00	$6.00-11.00	$8.00-11.00
DESHLER-WALLICK, Broad and High Sts.	$3.50-9.00	$6.00-14.00	$6.00-14.00
FT. HAYES, 31 W. Spring St.	$4.50-6.00	$6.50- 8.50	$7.00- 9.00
CHITTENDEN, High and Spring Sts.	$2.75-4.00	$5.00- 6.00	$7.00 and up
SENECA, 361 E. Broad St.	$3.50 and up	$5.00 and up	$7.00 and up
SOUTHERN, High and Main Sts.	$2.50 and up	$4.00 and up	$5.00 and up
VIRGINIA, Third and Gay Sts.	$3.00-4.00	$4.50- 5.50	$6.00- 7.00
BROAD-LINCOLN, 631 E. Broad St.	$3.00 and up	$5.00 and up	$7.00 and up

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager _____ Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 19, 20, 21, 22, 1949, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite

Arriving April _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

Regional Blood Center Opened . . .

Columbus Academy and Surrounding County Medical Societies Are Now Participating in Red Cross Program; Distribution Methods Outlined

AFTER ten months of detailed planning, the Columbus Regional Blood Center of the American Red Cross was opened on December 7. It is located in the new headquarters building of the Franklin County Chapter at 30 East Town St. in Columbus, near the heart of the shopping district and easily accessible to donors.

The National Blood Program of the Red Cross is expected to take five years to reach complete operation, the Columbus Center being the eighteenth to be opened in the nation.

Its purpose is to provide blood or plasma without charge to all who need it, regardless of race, color, or creed, in sufficient quantities. The Red Cross provides the blood free to physicians and hospitals. The only charge to patients is the hospital's laboratory charge and the physician's fee for administration of the blood.

At 30 East Town St., Chapter offices and the Blood Center share the street floor. In small rooms of the Center, case histories of the donors are taken by registered nurses, and precautionary steps, such as taking of blood pressure, pulse and temperature, and hemoglobin tests are accomplished. The collection-room is fitted with eight especially constructed cots, and in an attractive Canteen, donors are served light snacks after they have given blood.

Donors are greeted and registered by members of Red Cross Volunteer Gray Lady and Staff Aide Services, and the registered nurses are assisted by Volunteer Nurses' Aides.

FULLY EQUIPPED

This peacetime Center differs from the wartime Blood Centers, in which the blood collected was shipped out each night to larger centers to be processed into plasma. The new Center is fully equipped with laboratories in which the blood is tested, typed, processed and refrigerated. The laboratory equipment is the finest and most modern to be found anywhere.

A walk-in refrigerator in the laboratory, large enough to store 1000 pints each of blood and frozen plasma, has three different temperature compartments, one for keeping whole blood at 4-6 degrees Centigrade, a unit for deep-freezing plasma, and a storage compartment for the frozen plasma. Blood collected in the Center is delivered to the hospitals as whole blood, and if not used within 18 days is returned to the Center to be made into frozen plasma and other derivatives.

A Bloodmobile unit staffed with a doctor and six nurses has started making regularly scheduled visits to towns in 20 counties in Central Ohio. It is anticipated that eventually 30 counties will participate in the program of the Columbus Regional Center. Approval of the program by the medical society of each county served and participating is necessary.

Counties participating at present are: Ashland, Athens, Champaign, Coshocton, Crawford, Delaware, Fairfield, Franklin, Hardin, Knox, Licking, Logan, Madison, Marion, Miami, Perry, Pickaway, Richland, Ross and Shelby.

The following counties are expected to begin participation in the near future: Clark, Clinton, Fayette, Greene, Hocking, Morrow, Muskingum, Union, Vinton and Wyandot.

BLOODMOBILES

Blood collected by the Bloodmobile in all counties participating, is returned in refrigerated containers to the Center, where it is processed. Within 72 hours, whole blood is returned to the hospitals of that county. If there is no hospital in the county, blood is furnished on request to physicians, or a physician may obtain the blood from a hospital in an adjoining county, which hospital will receive later from the Red Cross Center a supply equal to the amount it disbursed to the physician. Red Cross blood will not be made available in any but a participating county.

The coordination of the Blood Center with local medical facilities is directed by a Blood Service Committee composed of Dr. Charles A. Doan, dean of the College of Medicine, Ohio State University, chairman; Dr. Harve M. Clodfelter, president of the Columbus Academy of Medicine, chairman of the Physicians' Advisory Committee; Delbert L. Pugh, executive director of the Columbus Hospital Federation; Dr. Ollie M. Goodloe, Columbus City Health Commissioner; and Richard M. Allison, chairman of the Donor Recruitment Committee. This group worked closely with the Board of Directors of the Franklin County Chapter of the Red Cross in establishing the Center. The medical society in each participating county has been asked to name a medical advisory committee to the local Red Cross agency.

Dr. John W. DeVore, a graduate of the College of Medicine, University of Oklahoma, is the physician-technical director of the Center. Working with him is a staff of twelve registered

nurses, four medical technologists and three blood custodians.

The Center makes collections from donors at specified hours during the week, but is open 24 hours a day to meet emergency requests from physicians and hospitals. The first routine distribution of blood to Franklin County hospitals began the third day following the opening of the Center. Three hundred pints of whole blood were distributed to nine Columbus hospitals, and several pints had previously been released for emergency requests. From now on, hospitals will receive whole blood in requested amounts on each Monday morning. Quantities will increase in direct proportion to the number of donors.

Ohio General Practitioners Complete Organization Plans in State

Officers and directors of the Ohio Academy of General Practice report that a complete organization plan is now a reality, according to a communication received from Dr. Joseph Lindner, its president.

There is now a local general practice organization within reach of every physician in Ohio, according to the announcement, and it is intended that membership will be simultaneous in a local, the state organization, and the American Academy of General Practice.

As rapidly as facilities will permit, every physician in Ohio will receive a membership campaign letter giving detailed instructions for becoming a member of Organized General Practice. Anyone who does not receive this communication may obtain it by writing Dr. Lindner at 3405 Clifton Ave., Cincinnati 20.

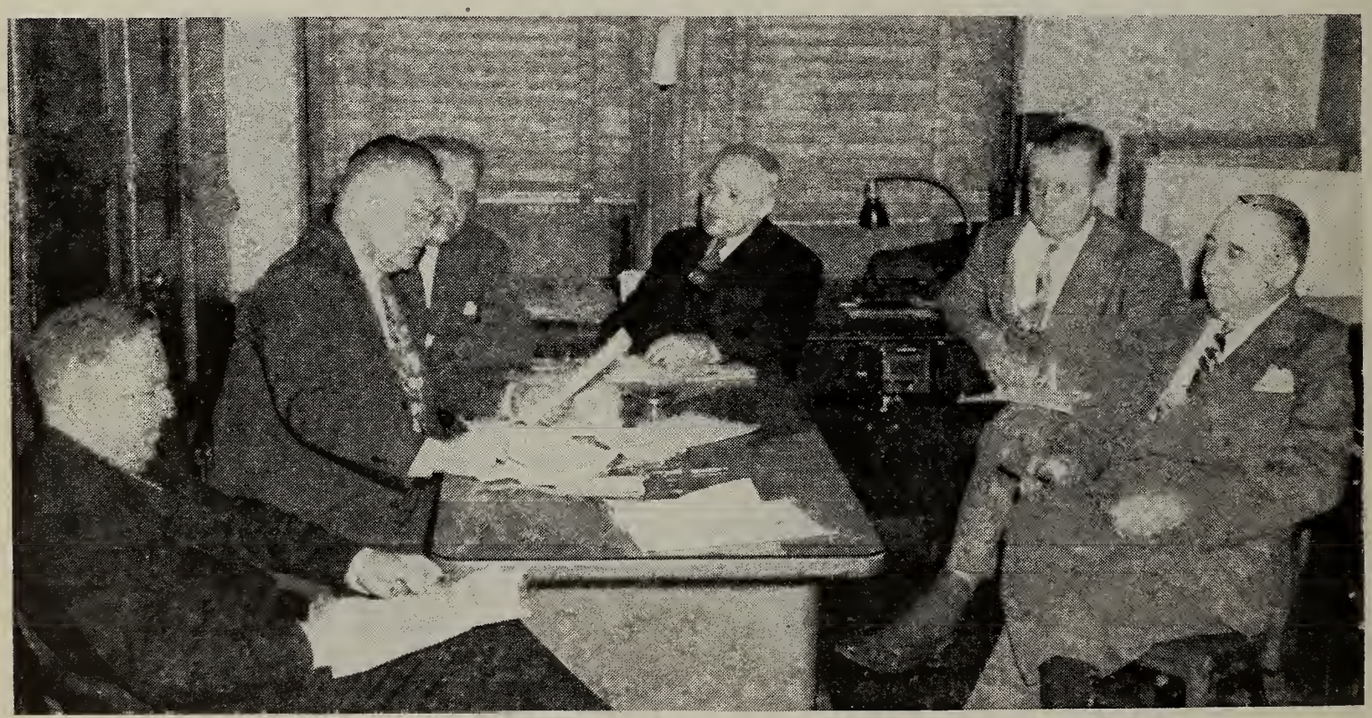
Ohio has the honor of having the first National Convention of the American Academy of General Practice. It will be held March 7-9 at the Netherland Plaza Hotel, Cincinnati, with Indiana, Kentucky and Ohio as host states.

Every effort is being expended to make the meeting successful. Outstanding scientific papers and exhibits are scheduled, with a well-rounded representation of commercial exhibitors. The good time aspect is not being overlooked. The women will have an interesting social program. The convention banquet on Tuesday evening promises delightful entertainment, an interesting speaker and a momento for each attendant.

The officers and directors have urged every physician doing general practice to make every effort to attend the meeting and thereby give full appreciation to Ohio's honor in having this first Scientific Assembly of the Academy.

It is planned that every physician will receive particulars about the meeting from the national headquarters. Information may be received by writing Mr. Mac F. Cahal, executive secretary, American Academy of General Practice, 231 W. 47th St., Kansas City 2, Mo.

Committee on Scientific Work Studies Annual Meeting Program



Detailed work on planning the scientific program for the Annual Meeting of the Ohio State Medical Association to be held in Columbus, April 19-22, 1949, began almost as soon as the last meeting was over. Shown above are members as they met at the Association's Headquarters Office in Columbus on November 14 to round out the program. Left to right are: Dr. Charles A. Doan, Columbus; Dr. Louis G. Herrmann, Cincinnati, chairman; Mr. George H. Saville, director of public relations for the Association; Dr. M. Paul Motto, Cleveland; Dr. Frank W. Anzinger, Springfield; and Dr. Martin W. Diethelm, Toledo.

Ohio Medical Indemnity . . .

Prepaid Medical Plan, Sponsored by O. S. M. A., Shows Remarkable Growth; Now Covers About 450,000 Persons; Schedule Liberalized

OHIO Medical Indemnity, Inc., the prepaid medical expense plan sponsored by the Ohio State Medical Association, concluded on December 31, 1948, an exceedingly successful year and is now the fifth largest voluntary prepaid medical care plan in the country, according to Mr. Charles H. Coghlan, executive vice-president of the company.

Ohio Medical has approximately 184,000 contracts in force and approximately 450,000 persons covered. These individuals for the most part are enrolled in groups through the payroll deduction procedure. There are now more than 4,000 Ohio firms and businesses throughout the state cooperating with the company on this matter.

The coverage is now available in 82 of Ohio's 88 counties. Enrollment of subscribers and numerous administrative details are carried on by seven Blue Cross Plans in Ohio under agreements with Ohio Medical. These plans are located in the following areas: Akron, Canton, Cincinnati, Columbus, Lima, Toledo and Youngstown. The home office of Ohio Medical is located at 79 East State Street, Columbus 15.

ENROLLMENT EXTENSIVE

The Ohio Medical enrollment in these areas as of November 30, 1948, was: Akron, 23,416; Canton, 51,559; Cincinnati, 194,218; Columbus, 95,313; Lima, 3,351; Toledo 53,634; Youngstown, 23,974. The company has only been in operation in the Lima area for two months.

Since January 1, 1946, when the company started business, slightly more than 43,000 claims have been paid. Indemnity payments by the company have totalled approximately $2,500,000 and it is now paying out approximately $180,000 monthly in benefits to subscribers. The company has made a special effort to pay claims promptly. Because the contract of the company is broad and relatively free from exclusions, it has been able to use simple claim forms. This has expedited the handling of claims and has kept the paper work required of claimants and physicians at a minimum. The over-all administrative expense of the company has been slightly less than 15 per cent of premium-income, meaning that the company has been able to pass on a large proportion of its income to subscribers in the form of benefits.

ADEQUATE RESERVE

At the same time the company has set up adequate reserves to meet pending claims, anticipated claims, and for unknown contingencies. These now total approximately $500,000 which the Board of Directors believes is in line with the substantial operations of the company.

Mr. Coghlan emphasized in his statement that during 1948 upward revisions in many items of the schedule of indemnities were made; additional indemnities inserted in the schedule; and certain limitations which were originally in the subscribers' contract were eliminated. Some of the modifications in the contract were cited by Mr. Coghlan as follows:

Certain surgical procedures performed in the physician's office or elsewhere were inserted in the indemnity schedule. This new benefit provides that payment will be made to the subscriber for surgical service rendered in the doctor's office or elsewhere whenever the indemnity payable under the contract is $15.00 or more. This assists the subscriber located some distance from a hospital, enabling him to receive payment for services rendered by a physician in his office and avoiding the necessity for the subscriber to enter the hospital.

An indemnity covering emergency suturing of wounds in a physician's office following an accident also has been added to the indemnity schedule. This is not subject to the $15.00 limitation referred to above.

WAITING PERIODS MODIFIED

The six months' waiting period on tonsillectomies and adenoidectomies was eleminated. This means that Ohio Medical now provides immediate protection, beginning with the effective date of the contract, for all conditions covered by the contract, except obstetrics. A nine months' waiting period for obstetrical cases still is required.

Indemnities have been increased for a large number of procedures, including the following: Amputation of thigh through hip joint or neck of femur and arm through shoulder joint; mastoidectomy; excision or fixation by cutting of hip or shoulder joint and joints of elbow, wrist or ankle; cutting on extrinsic eye musles; cystoscopic examination and cystoscopy for removal of urinary stones or bladder tumor; resection of fistula; amputation of finger or toe and fingers or toes; various sinus operations.

Among indemnities added to the schedule were the following: Biopsy of breast; gastro-enterostomy; six procedures involving endoscopy

(bronchoscopy and esophagoscopy); and eleven new procedures involving surgery of the eye.

MINIMUM AGE DECREASED

Other actions taken which benefit subscribers included the following: Coverage of infants after 30 days of age, instead of 90 days as originally specified; liberalization of the schedule of indemnities with respect to multiple surgery performed at the same time or different surgical operations performed at different times within the same six months' period.

These more liberal benefits and added benefits have been provided by the company without an increase in the premiums paid by subscribers, which remain at 60 cents per month for a single subscriber and $1.90 per month for a subscriber and dependent members of his family.

A special Committee on Medical Care has been named by the Board of Directors to study the matter of adding indemnities for medical (non-surgical) services received by subscribers. This committee is assembling actuarial data and data on the experiences of other plans which have been in operation longer than Ohio Medical. Coverage for medical services will be inserted in the schedule of indemnities at the earliest feasible time. Also, another committee is studying the possibility of adding indemnity for anesthesia and still another committee is considering the question of providing coverage for X-ray.

LOANS REPAID

Also, during the year Ohio Medical repaid to various physicians the original capitalization loan of $100,000 which the company was required by law to have before starting business. All outstanding stock of the company, which has no dividend yield, is now held by the Ohio State Medical Association.

Mr. Coghlan stated that information received from the National Blue Shield office, Chicago, shows that more than 10,000,000 persons are now enrolled in Blue Shield Plans, similar to Ohio Medical, and that about 33,000,000 persons are enrolled in Blue Cross hospitalization plans.

Michigan Anatomy Courses

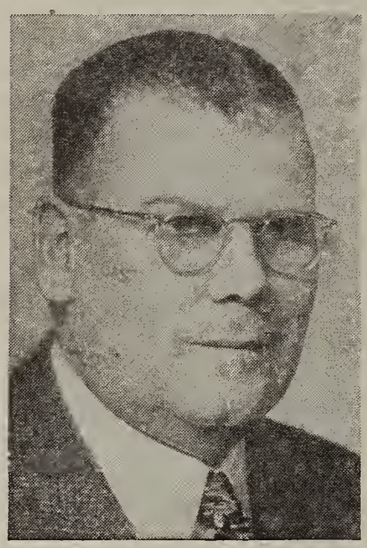
Courses in anatomy under direction of Professor Russell T. Woodburne are being offered at the University of Michigan Department of Postgraduate Medicine, Ann Arbor, to physicians wishing a review in this field. Such courses are offered especially to surgeons and those preparing for specialty board examinations.

Courses will run simultaneously. They will be given on Thursdays beginning February 10 at 1 p. m. and will end May 26. The fee for either course is $40. Further information may be obtained by writing Dr. John M. Sheldon of the postgraduate department.

Dr. Charlton Is Appointed to The State Medical Board

Governor Thomas J. Herbert early in December announced the appointment of Dr. Paul H. Charlton of Columbus to the State Medical Board for a term ending in March, 1955, to succeed Dr. J. H. J. Upham, whose term expired last March.

Dr. Upham, whose unlimited contributions to the medical profession both from the standpoint of education and organization work, is well known to Ohio physicians, expressed a desire to be relieved from the Board after completing 35 years as a member of that body.



P. H. CHARLTON, M. D.

Dr. Charlton is clinical associate professor of surgery at the Ohio State University College of Medicine, from which institution he received his medical degree in 1921. He received an M. Sc. degree from the University in 1923.

During World War I, Dr. Charlton served as a major with the 37th Division. He is an active participant in the medical profession organizations; is a member of the Ohio State Medical Association through the Columbus Academy of Medicine, and a Fellow of the American Medical Association.

In addition, he is a member of the Medical Section of the American Life Convention, the Association of the Life Insurance Medical Directors of America, and a Fellow of the American College of Surgeons.

Dr. Charlton was engaged in the private practice of surgery in Columbus from 1926 to August, 1947, at which time he retired from private practice to become Medical Director of the Midland Mutual Life Insurance Company of Columbus.

Prosthetic Fitters Certification

To improve the professional standards of manufacturers of artificial limbs and braces, and the fitters employed by such firms, an American Board for Certification has been established with headquarters at 336 Washington Building, Washington, D. C. Three orthopedic surgeons and four leaders in the orthopedic appliance industry constitute the national board which will grant certification.

Ohio Rural Health Council . . .

Fifth Annual Conference Scheduled in Columbus, Feb. 28-March 1; Topics of Vital Interest to Rural Health and Welfare on Program

THE Ohio Rural Health Council, an organization of farm groups, the Ohio State Medical Association, and others interested in the improvement of rural health, will sponsor its fifth annual State Conference on Rural Health February 28-March 1, at the Southern Hotel in Columbus.

The program for the first day will begin with an address by George H. Lasher, D. V. M., Rutland, chairman of the Council. He will introduce Floyd Lower, Columbiana County agricultural agent, who will discuss the "Health Organization and Program in Columbiana County."

A paper on "Animal Diseases Affecting Man," is also scheduled for the morning session. It will be presented by James H. Steele, Atlanta, chief veterinarian of the U. S. Public Health Service.

During the afternoon, four discussion groups will be formed from the conference. The subjects presented by the speakers of the morning will be considered and the results of the discussion will be reported for further deliberation by the general session reconvening late that afternoon. Charles S. Nelson, executive secretary of the Ohio State Medical Association, has been appointed as the discussion leader for one of the groups.

At the annual dinner meeting that evening, Dr. Jonathan Forman, Editor of *The Journal*, has been chosen to address the conference on the subject, "Diet and Health." Reports on the youth health programs of the 4-H Clubs, Grange, Farm Bureau and the school and community also will be heard.

Five talks have been scheduled for the morning of the second day, with the session scheduled to convene at 9 a. m.:

"Progress in Combining Health Districts"—John D. Porterfield, M. D., director, Ohio Department of Health.

"Progress in Hospital Building Program"—A. J. Borowski, Dr. P. H., Chief, Office of Hospital Facilities, Ohio Department of Health.

"National Health Assembly"—H. C. Nisonger, director, Bureau of Special and Adult Education, Ohio State University.

"Improving Public Health Setup in Ohio"—Charles S. Nelson, executive secretary, Ohio State Medical Association.

"Minimum Essentials for an Effective Local Public Health Program"—Dr. Carl E. Buck, professor of public health, University of Michigan.

The discussion groups are scheduled to meet again following these addresses. They are scheduled to report at 2 p. m., and from 3 p. m. until adjournment at 4 p. m., there will be a general discussion of the reports.

DISTRICT CONFERENCE, WILMINGTON

The second of the series of district conferences sponsored this fall and winter by the Ohio Rural Health Council was held December 3 in Wilmington.

Two problems, mental hygiene and communicable disease control, were selected for discussion at this conference.

The speakers were Dr. Roger M. Gove, Piqua, director, Upper Miami Valley Guidance Center, who talked on "Mental Health Program of a Community Guidance Center"; and Dr. R. E. Wehr, assistant health commissioner, Cincinnati, who presented a paper on "Providing an Adequate Public Health Program in Areas of Sanitation and Communicable Disease Control."

Following these talks the meeting was divided into five discussion groups each considering one of the following subjects: "Mental Health," "Protecting Families from Menace of Livestock Diseases," "Sanitation in Relation to Our Public Health," "Communicable Disease Control," and "Effective Public Health Programs." Dr. J. Martin Byers, member of the Committee on Rural Health of the Ohio State Medical Association and Hart F. Page, its secretary, served as discussion leaders.

Following the reports of the discussion groups to the general session, Allan Greenlee, D. V. M., public health veterinarian, Ohio Department of Health, discussed diseases common to animal and man.

The following physicians registered at the conference: Dr. H. A. Moore, Oxford; Dr. W. H. Gaskins, Batavia; Dr. R. W. DeCrow, Wilmington; Dr. E. K. Yantes, Wilmington; Dr. Maurice Kane, Greenville; Dr. J. Stewart Mathews, Wyoming; Dr. Byers; Dr. Gove; Dr. John F. Torrence, Germantown; Dr. Wehr; Dr. Gordon E. Savage, Xenia; Dr. George E. Rockwell, Milford; Dr. Robert Conard, Wilmington; Dr. W. S. Ramsey, Delaware; Dr. W. M. Hoyt, Hillsboro; Dr. John S. Myers, Versailles; Dr. H. H. Pansing, Dayton; Dr. Brent Welch, Troy; Dr. Carle Beane, Eaton; and Dr. J. A. Carter, Middletown.

Industrial Commission . . .

$4,225,956 Disbursed by Ohio Agency for Medical Services in 1947, Report of Actuarial Section Shows; Claims Filed Totaled 293,530

THE Industrial Commission of Ohio paid out $4,225,956 for medical services to injured Ohio workmen during 1947, according to a report issued recently by H. H. Pickering, supervisor of the Actuarial Section. Included in the amount is a relatively small sum for dental services.

Other expenditures during the year, exclusive of compensation payments, included: $2,556,431 for hospital care and nursing; $126,032 for funeral expenses; $62,586 for court costs; and $13,771 for miscellaneous costs. With disbursements for medical services added, the total is $6,984,776.

These amounts include payments covering treatment of injured **private and public employees**, as well as similar costs for occupational disease claims.

Comparative figures for 1947 were as follows: $3,466,275.75, medical services; $2,045,106.88, hospital care and nursing; $108,515.12, funeral expenses; and $72,437.22, court and miscellaneous costs—a total of $5,692,334.97.

SUBSTANTIAL RISE IN CLAIMS

The number of claims filed during 1947 was 293,530, or 13 per cent more than in 1946. The rise was a substantial change in trend from decreases in 1944 and 1945 followed by a slight rise of 3.2 per cent in 1946. The peak year in number of claims during the 36-year history of the Ohio Workmen's Compensation Fund was 1943 when the number of claims reached 331,072, 81 per cent of which were "medical-only" claims. The average number of claims filed each working day in 1947 was 1,026.

"Medical-only" claims, involving payment for physicians' services, but no compensation to the claimant for loss of time, numbered 227,550 in 1947, or 78 per cent of all claims filed. The average amount paid out per "medical-only" claim increased from $9.06 in 1946 to $10.11 in 1947.

CONDITION OF FUND

In the report of the five-year audit by Woodward and Fondiller, Inc., is a statement of the financial condition of the Ohio State Insurance Fund as of December 31, 1947.

During 1947 the surplus of the fund concerned

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION

As of December 31, 1947

	FUNDS			
	Private	Public	P.W.R.E.	Total
ASSETS				
Bonds	$146,677,856.59	$7,758,270.21	$729,277.43	$155,165,404.23
Cash	7,577,861.96	400,817.83	37,676.88	8,016,356.67
Premiums in Course of Collection	1,573,321.02	1,308,075.58	1,340.16	2,882,736.76
Interest Accrued	727,143.44	38,460.99	3,615.33	769,219.76
TOTAL ASSETS	$156,556,183.01	$9,505,624.61	$771,909.80	$166,833,717.42
LIABILITIES				
Reserve for Compensation and Medical Benefits	$ 97,517,737.00	$7,149,221.00	$101,595.00	$104,768,553.00
Reserve for Contingencies	18,500,000.00			18,500,000.00
Unearned Premiums	8,841,496.00			8,841,496.00
Safety and Hygiene	441,660.01	24,674.56	103.29	466,437.86
Outstanding Warrants	1,789,783.56	108,641.88	427.61	1,898,853.05
Surplus	29,465,506.44	2,223,087.17	669,783.90	32,358,377.51
TOTAL LIABILITIES	$156,556,183.01	$9,505,624.61	$771,909.80	$166,833,717.42

TABLE 2

1947 Disbursements Distributed to Year of Injury Occurrence

(Accidents and Occupational Disease Combined)

Year of Accident or Disease	Compensation	Medical Hospital, etc.	Total	Per Cent
1947	$ 4,077,124	$3,367,379	$ 7,444,503	30
1946	3,155,676	2,230,055	5,385,731	22
1945	2,903,347	259,502	3,162,849	13
1944	2,073,270	141,102	2,214,372	9
1943	1,546,465	122,187	1,668,652	7
1942	1,081,751	76,227	1,157,978	5
1941	787,636	33,900	821,536	3
1940	414,219	11,008	425,227	2
1939	217,832	11,165	228,997	1
1938	178,192	29,206	207,398	1
1912 - 1937	1,702,374	144,798	1,847,172	7
	$18,137,886	$6,426,529	$24,564,415	100

with private employees increased $4,120,069.90, resulting in a total surplus of $29,465,506.44. The total assets increased $6,564,965.34, bringing the accumulated amount to $156,556,183.01, the highest in the history of the fund.

BASIC RATE CHANGES

Basic rates were lowered in 174 classifications, raised in 124, and remained unchanged in 33, according to the *Actuarial Review*.

Table 1 is a financial statement of the Ohio State Insurance Fund.

Table 2 gives 1947 disbursements that have been paid for active claims according to year of injury, and having injury dates which in some instances reach back to the beginning of the fund.

College of Surgeons Announces 1949 Sectional Meetings

The American College of Surgeons announced that six 2-day Sectional Meetings will be held between January 7 and April 13, 1949, for physicians and surgeons, and professional personnel of hospitals. A seventh meeting to be held in the West the latter part of April will be announced later. The schedule follows:

January 7-8—Edgewater Park, Miss., Edgewater Gulf Hotel; **January 14-15**—Houston, Texas, Rice Hotel; **February 11-12**—Kansas City, Mo., Hotel President; **March 15-16**—Washington, D. C., Statler Hotel; **March 21-22**—Buffalo, N. Y., Statler Hotel; and **April 12-13**—Edmonton, Alberta, MacDonald Hotel.

Conferences for the hospital personnel and for the medical groups will run concurrently. A joint meeting of the two groups will open at 8:30 a. m. each day with the showing of medical motion pictures, followed by separate sessions at 10:00 a. m.

Further information may be obtained by writing the College at 40 E. Erie St., Chicago 11, Ill.

General Practitioners Invited To Bring Wives to Cincinnati

With the invitation for general practitioners to attend the First National Convention of the American Academy of General Practice in Cincinnati, March 7-9, 1949, there comes a special invitation for each doctor to bring "the girl in your life." Wives of host doctors of Cincinnati will act as hostesses to the visiting ladies.

"Let someone else stay home to answer the phone and door bell," the invitation reads, "for our local 'better halves' are arranging some mighty appealing doin's for her while she's here."

Monday, March 7, there will be a grand tour of the city on new and comfortable busses, permitting plenty of opportunity "to discuss the relative merits of the other gals' hats and suits en route."

At the end of the trip, which will include the many really interesting spots in the Queen City, a tea will be served at Taft Museum. This is Robert A.'s and Charles P. Taft's boyhood home, from which "Papa" William Howard Taft was started on his career as President and Chief Justice. Taft Museum is a nineteenth century American home, rich in historical background, restored with the finest furniture, drapes and such of the period, and housing a priceless art collection. It is truly a "must" for everyone.

Tuesday, a "brunch" and style show will be held at one of the leading hotels. The very latest in spring and summer apparel will be shown. "The ladies must have some new things for that summer vacation, you know."

Acquisition of 20 acres of land in Cleveland for a 1,000-bed Veterans Administration general medical and surgical hospital has been authorized by Carl R. Gray, Jr., Administrator of Veterans Affairs.

Compulsory Health Insurance Issue Debated at Town Meeting

"How Much Government in Medicine?" was the subject discussed on Columbus Town Meeting, Sunday afternoon, December 12, in the Columbus City Hall council chamber and broadcast over radio station WBNS. The speakers were Dr. Paul R. Hawley, Chicago, chief executive officer, the Blue Cross and Blue Shield Commissions, and Donald Kingsley, Washington, D. C., assistant to Oscar Ewing, administrator of the Federal Security Agency. After each speaker stated his position in a brief talk, the remainder of the 50-minute broadcast was devoted to answering questions from the radio audience and from the floor. The moderator, was Earl F. Morris, Columbus attorney.

Kingsley advocated the enactment of the Truman-Ewing National Health Program, charging that there are serious weaknesses in our present health services.

"They can only be corrected by governmental action to expand our health facilities and services and to insure our people against the unpredictable financial consequences of accident and sickness," he said.

Mr. Kingsley said a system of national health insurance, when made fully operative, would make complete medical, dental and hospital care available to every person in the country, "at a cost well within the reach of the family pocketbook," and financed by means of a "small" deduction from the weekly pay check.

Answering Mr. Kingsley, Dr. Hawley said: "The necessity for prepayment of the costs of medical care through some form of insurance is no longer in dispute. The only points on which Mr. Kingsley and I disagree are the form such insurance should take and the extent to which it can be carried and still remain insurance rather than becoming a socialistic dole."

Dr. Hawley pointed out that the plan proposed by Mr. Ewing violates all insurance principles, in that the premiums to be collected from employer and employee bear no relationship to the risk involved, and are based on income rather than the amount of protection offered. He stated that the premiums represent only a small part of the cost of the benefits to be distributed, and that the deficit would have to be paid from general taxes.

Concluding his remarks, Dr. Hawley said: "The pattern of the economics of medical care must be changed at once. There can be no doubt of this. But, in changing the method of paying for medical care, we must be most careful not to disrupt the pattern of medical practice which has brought American medicine to its present high quality, and which promises even greater achievements in the immediate future.

"The only safe step lies in the expansion of the existing voluntary plans for the prepaying of the costs of medical care. These do not compel anyone to do anything; their cost is easily within the reach of all but the indigent —and we have always provided medical care for those who can pay nothing—and these voluntary plans do protect against the really serious costs of illness. Granted that they are, at present, far from perfect. They are being improved and expanded rapidly, and they can be made to answer every real requirement. They preserve everything that has been found to be good in medical care, and they protect against the only thing that has been found to be bad—the cost."

General Practice Chapter Formed In Fourth District

A chapter of the American Academy of General Practice, to include general practitioners in the Fourth Councilor District recently was organized with the initial meeting at Defiance. Dr. Wayland B. Recker of Leipsic and Dr. D. J. Slosser of Defiance were pioneers in the organization movement.

William Bashford Richards, D. D., superintendent of White Cross Hospital, Columbus, addressed the group at the organization banquet on the subject, "Europe As I Saw It." His talk centered around socialistic trends in Europe, especially as they relate to the practice of medicine and hospitalization.

Dr. Recker was elected president with the following other officers: Dr. Herman W. Mannhardt, Bowling Green, pres.-elect; Dr. Slosser, secy.; Dr. J. S. Hull, Hicksville, treas.; Dr. Munroe W. Palestrant, Continental, program chairman.

Trudeau Society Course Scheduled In Indianapolis, March 7-12

The American Trudeau Society and affiliated county and state tuberculosis associations are again sponsoring a postgraduate course in thoracic diseases for chest physicians. The one-week course will be given at the Indiana University School of Medicine, Indianapolis, Ind., March 7-12.

Application blanks for the course may be secured from county tuberculosis associations or from the Ohio Tuberculosis and Health Association, 1575 Neil Avenue, Columbus 1, Ohio.

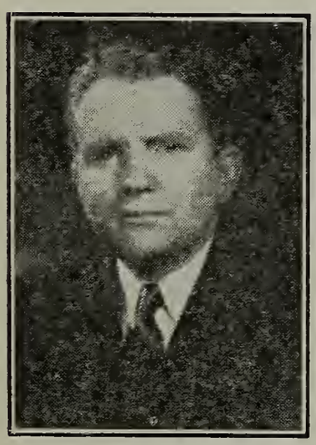
In order to encourage physicians in Ohio to attend the course, the Ohio Tuberculosis and Health Association is offering three $100 scholarships to qualified physicians. Physicians applying for admission to the course and for the state scholarship must return the applications to the Ohio Tuberculosis and Health Association by January 17.

Defense Medical Advisory Committee . . .

Meiling of Ohio Named on Washington Group to Advise Secretary Of Defense on Part Played by Medicine in National Security Picture

ACTION by Secretary of Defense James Forrestal recently in appointing an Armed Forces Medical Advisory Committee is official recognition of the important role of medicine, not only in the defense picture but in the over-all functions of government.

Among members of the newly-created Committee is Dr. Richard L. Meiling of Columbus, member of the Ohio State Medical Association's Committee on National Emergency Medical Service, and member of the American Medical Association's Council on National Emergency Medical Service. Dr. Meiling is assistant professor of obstetrics and gynecology at the Ohio State University College of Medicine.



R. L. MEILING, M. D.

The directive establishing the Committee places it on the top level of the National Military Establishment, on a plane with the Joint Chiefs of Staff, the War Council, the Munitions Board, and the Research and Development Board. The power of the Committee is further emphasized by the fact that its chairman is designated as deputy to the Secretary of Defense.

The Committee will serve in an advisory capacity to the Secretary of Defense on questions which affect the Armed Services as a whole in the fields of medicine and its allied professions. The Committee will make recommendations in respect to the establishment of general policies and programs for the National Military Establishment as a whole; the development of medical and allied services capable of efficiently and effectively supporting the missions and heads of the armed services; the elimination of unnecessary duplication or overlapping, and the development of the "maximum degree of continuing cooperation and mutual understanding between members of the civilian medical and allied professions and the armed services."

IN PEACE AND WAR

The Committee will concern itself with the foregoing matters, not only as they relate to the armed forces in peacetime, but also as they concern plans for mobilization in the event of any future national emergency.

The Committee was directed to give advice or assistance to the Secretaries of the Army, the Navy and the Air Force, the chairman of the Research and Development Board, the chairman of the Munitions Board, or the head of any other board or agency in the National Military Establishment, with respect to any problems in the fields of medicine and allied professions.

In keeping with the responsibilities and duties vested in it, the Committee has authority to consult with any person within the National Military Establishment for information and assistance and to request the help of any other individuals or agencies (both governmental and non-governmental) when such help is appropriate. The Committee will determine its own organization and establish its own rules and procedures within the limits prescribed by law, and will operate through its own secretariate.

TEN DOCTORS NAMED

The directive establishing the Committee calls for a civilian chairman, the Surgeons General of the Army and Navy, The Air Surgeon, and "not less than three other individuals." Actually the Committee consists of 12 persons, 10 of whom are physicians.

Civilian members in addition to Dr. Meiling are: Charles Cooper, chairman, board president of Presbyterian Hospital, New York City, formerly an American Telephone & Telegraph Company official; Dr. Maurice Pincoffs, professor of medicine and chairman of the Department of Medicine, University of Maryland; Dr. Edward D. Churchill, chairman of the Department of Surgery, Harvard Medical School; Dr. Howard A. Rusk, professor of rehabilitation and physical medicine, New York University College of Medicine, and medical editor for the *New York Times*; Dr. Paul R. Hawley, chief executive officer of the Blue Cross-Blue Shield Commission; Dr. Raymond Allen, physician and president of the University of Washington, Seattle; Dr. Michael A. DeBakey, professor and chairman of the Department of Surgery, Baylor University College of Medicine, Dallas, Texas; Dr. Paul Titus, Pittsburgh, secretary of the American Board of Obstetrics and Gynecology, Inc.; and Walter H. Scherer, D. D. S., Houston, Texas, past-president of the American Dental Association.

Dr. Meiling has been untiring in his efforts to place medicine in a position to guide and estab-

lish medical policies at the national level. He and Dr. Rusk were consultants to the Eberstadt Committee of the Hoover Commission, which Commission is nearing the end of its gigantic task of studying organization of the Federal government's executive branch and recommending steps for overhaul. Dr. Allen was a member of the Eberstadt Committee. It was the Eberstadt Committee which had the responsibility for studying the National Security Organization. Dr. Meiling and Dr. Rusk also served as liaison officers to the Voorhees' Committee which has been called the "medical task force" of the Hoover Commission. Drs. Hawley, Churchill and DeBakey served on the Voorhees Committee.

MEDICINE TWICE RECOGNIZED

The appointment of the Armed Forces Medical Advisory Committee marks the second time within the year that the medical profession has been recognized in the top echelons of the executive branch of the government. This summer the Medical Advisory Committee to the Chairman of the National Security Resources Board was appointed. This committee consists of five physicians and one dentist. Included on the committee are Dr. Edward L. Bortz, Philadelphia, past-president of the American Medical Association, and Dr. James C. Sargent, Milwaukee, chairman of the A. M. A. Council on National Emergency Medical Service.

The National Security Resources Board, created by the Security Act of 1947, is responsible for advising the President on all matters concerning military, industrial and civilian mobilization.

Dr. Upham Named Emeritus Member Of State Medical Board

Members of the Ohio State Medical Board at their December meeting passed the following resolution:

"For thirty-five years, the people and medical profession of Ohio have been most fortunate to have as a member of the Ohio State Medical Board, a man who has given unstintingly of his talents, energy and time.

"Now, as Dr. J. H. J. Upham relinquishes membership on that Board, it is fitting and proper that all honor and praise be accorded him and thanks and best wishes be extended to him. The Ohio State Medical Board, therefore, genuinely regrets his loss as an active member but designates him as Member Emeritus of the Board, by unanimous action, in regular session this fourteenth day of December, 1948."

Dr. Upham's fifth term as a member of the Board expired in March, 1948. Dr. Paul H. Charlton of Columbus was appointed in December to succeed him as an active member.

Do You Have Resolutions for House of Delegates?

At the 1948 session of the House of Delegates of the Ohio State Medical Association a resolution was adopted stating that "whenever possible all resolutions for consideration by the House of Delegates shall be submitted in advance of the Annual Meeting to permit publication of such resolutions in the issue of The Ohio State Medical Journal appearing at least 30 days prior to the Annual Meeting."

Therefore, members of the Association or County Medical Societies are requested to give immediate attention to the intent of the above-quoted resolution.

The 1949 Annual Meeting will be held in Columbus on April 19-22, inclusive. Those having resolutions should submit them to the Columbus Office in time for publication in the March issue of The Journal. Copy for that issue must be in the hands of the Columbus Office on or before February 18, 1949.

The action of the House of Delegates is not mandatory but merely an attempt to provide delegates with information in advance of the Annual Meeting on questions which will be considered.

Activities of The Editor

Dr. Jonathan Forman, Editor of *The Journal*, has been elected first chairman of the Board of Trustees of the newly-organized Franklin County Historical Society. Following are some other recent activities in which Dr. Forman engaged.

He addressed the annual meeting of the State's Society of Soil Conservation District Supervisors held in Oklahoma City.

He addressed the annual meeting of the Friends of the Land on "What Conservation Can Mean to the Health of the Nation."

Dr. Forman read a paper before the Kit Kat Club of Columbus on the subject, "Our Plundered Planet."

He attended the annual meeting of the Board of Directors and members of the Ohio Chamber of Commerce. Dr. Forman is serving his third term on that Board.

He participated in a panel discussion on Migraine before the Ohio Valley Allergists Society held in Springfield.

He addressed the combined meeting of the Woman's Auxiliary to the County Medical Societies of Fayette, Pickaway and Fairfield counties on the subject of medical legislation during the coming year.

A.M.A. Public Relations Program . . .

House of Delegates Votes to Levy Assessment; Method of Collection Is Being Developed; Follow-Up Information to Members Promised

THE most important action taken by the House of Delegates of the American Medical Association at the recent St Louis interim session of the A. M. A. was the adoption of a resolution authorizing the Board of Trustees to levy an assessment of $25.00 on each member of the American Medical Association to provide funds for the following purposes:

Expansion of the Washington Office of the American Medical Association.

Initiation of a national educational and public relations program to:

Enlighten the American people about the many contributions of the medical profession to the health of individuals and the nation as a whole;

Give the people accurate information regarding medical and health matters;

Stress to the people the importance of the present system of voluntary medical care and the value of the voluntary prepaid medical and hospital service plans;

Enumerate what the medical profession has done, is doing, and will continue to do, to try to help the people meet the social and economic problems which are related to the costs of medical care and the distribution of medical services;

Emphasize to the people the constructive activities which the medical profession is carrying on in cooperation with voluntary organizations and governmental agencies in the health-welfare fields;

Warn the people of the dangers of any proposal providing for a program of health and medical services, controlled by government or otherwise, which would contribute to a lowering of the standards of medical care, public health activities and medical education;

Urge public support for all medical and health programs which would make definite contributions to the health of the people, produce a wider distribution of good medical care, and provide sound ways of solving the economic problems of health and medical care.

Employment of suitable public relations counsel to assist in the execution of this program in cooperation with a special coordinating committee which would direct this nation-wide educational program on behalf of the A. M. A. and in cooperation with the various state and local medical societies.

At a meeting of The Council of the Ohio State Medical Association on December 12, The Council endorsed the action of the A. M. A. House of Delegates and offered the cooperation of the State Association's Headquarters Office on the matter of collection of the assessment. Plans for the collection of the assessment are now being developed. Each member will receive specific information at the appropriate time, together with detailed information about the A. M. A. education program, how it will operate, etc.

Members should keep in mind that the levying of the A. M. A. assessment is not tied in with dues paid by members to their local medical society and the Ohio State

Medical Association. They should pay their regular local and state dues immediately to their local Secretary-Treasurer. Collection of the assessment will be handled independently.

Moreover, those desiring to be Fellows of the A. M. A. and receive 52 issues of The Journal of the A. M. A. and other special benefits, should send their Fellowship dues of $12.00 direct to the A. M. A. office, Chicago, as in the past. Members of the A. M. A. have never paid membership dues. The assessment which has been levied is the first request ever made by the A. M. A. for a financial contribution from members.

Obviously, many different opinions have been expressed regarding the action of the A. M. A. since the publication of the information in newspapers, magazines and via radio.

Among physicians who have voiced an opinion the majority appear to feel that the A. M. A. program is necessary and desirable and that it should receive the wholehearted support, financially and otherwise, of the membership. Naturally, some are of the opinion that similar action should have been taken long ago. There are some who don't like the idea. They can be listed as those who believe that a public educational program is either unnecessary or too late; or those who favor some of the proposals about which the public will be warned.

At any rate the A. M. A. through its House of Delegates has taken definite, affirmative action—something which many members have been crying for—and it is asking the members of the Association to underwrite the job—something which, unfortunately, certain other independent organizations have tried to assume.

The success of the program will depend on how well the profession responds.

In addition to the assessment, the House of Delegates took action on a number of other important matters, among which were those summarized below.

GENERAL PRACTITIONER AWARD

The gold medal of the A. M. A. "for exceptional service by a general practitioner" this year was awarded to Dr. W. L. Pressly of Due West, S. C. Dr. Pressly was elected by the House from three nominees selected by the Board of Trustees.

BLUE CROSS-BLUE SHIELD

The House rejected the proposal of Associated Medical Care Plans to form a national insurance company in cooperation with Blue Cross. It did approve formation of a national enrollment agency for Blue Cross-Blue Shield plans.

MILITARY NEEDS

The need of physicians for the military forces was emphasized and the obligation of the medical profession to do everything possible to supply this need on a voluntary basis was stressed.

LAYMAN AWARD

A certificate of appreciation and a gold medal, emblematic of outstanding effort for the public welfare on a national level, were awarded to the Rev. Alphonse Schwitalla, S. J., Dean of St. Louis University Medical School, by the House of Delegates. Dr. E. J. McCormick, Toledo, member of the A. M. A. Board of Trustees, and president of the alumni association of St. Louis University Medical School, made the presentation.

REBATES

The House in a resolution reiterated its condemnation of the practice of any member of the A. M. A. accepting rebates and also the practice of giving rebates. The House "urges that the different state societies in those states in which such practices are not now illegal give serious consideration to the introduction of legislation making the practice of rebating to or by physicians illegal."

The report approved by the House of Delegates continues as follows: "Your Committee recommends further to the component county societies that on the receipt of a bona fide complaint the disciplinary committee of that society should hold a hearing and endeavor to make an investigation of the doctor's records and accounts at society expense, and that a record of such hearings and examination should be kept for the information of the state society and, if necessary, for the Judicial Council of the American Medical Association."

REGISTRATION

Total registration for the Interim Session was 4,526, more than twice that at the session last year in Cleveland. This figure included 2,200

physicians, 1,113 guests, 219 technicians, 173 nurses, 337 interns, and 484 medical students.

OHIO DELEGATION

Delegates of the Ohio State Medical Association who attended the St. Louis session were: Dr. Edgar P. McNamee (alternate), Cleveland; Dr. Carl A. Lincke, Carrollton, President-Elect of the Association; Dr. George A. Woodhouse, Pleasant Hill; Dr. William M. Skipp, Youngstown; Dr. Frank M. Wiseley, Findlay; Dr. L. Howard Schriver, Cincinnati; and Dr. C. C. Sherburne, Columbus.

Others attending in official capacity were: Dr. A. A. Brindley, Toledo, President of the Association; Dr. Edward J. McCormick, Toledo, member of the A. M. A. Board of Trustees; Dr. Jonathan Forman, Columbus, Editor of *The Journal*; Dr. Carll S. Mundy, Toledo, member of the A. M. A. Council on Rural Health, to which he was elected chairman. The executive staff of the O. S. M. A. headquarters office in Columbus, including Mr. Charles S. Nelson, executive secretary, Mr. George H. Saville, Mr. Hart F. Page and Mr. Gordon Moore, attended the Interim Session as well as the National Medical Public Relations Conference, the Conference of State Medical Association Secretaries and Editors, and the National Conference of County Medical Society Officers.

Dr. Sherburne served as a member of the Reference Committee on Legislation and Public Relations; Dr. Lincke served on the Reference Committee on Credentials; and Dr. Skipp acted as one of the House tellers.

National Preparedness Is Theme At Grass Roots Conference

Four top-notch authorities on "national preparedness" drew an over-flowing crowd to the fourth "Grass Roots Conference," or National Conference of County Medical Society Officers, which was held Tuesday, November 30, in St. Louis.

Dr. Richard L. Meiling, Columbus, member of the Ohio State Medical Association's Committee on National Emergency Medical Service, and also a member of the A. M. A.'s Council on National Emergency Medical Service, discussed the subject, "Relation of the Doctor to National Preparedness," from the viewpoint of the medical profession.

Others taking part in the discussion were Brig. Gen. George E. Armstrong, deputy surgeon of the Army, and Rear Admiral Joel T. Boone, executive secretary of the Committee on Medical and Hospital Services of the Armed Forces, who discussed the viewpoint of the armed services; and Dr. Norvin C. Kiefer, senior surgeon, U. S. Public Health Service, who discussed civilian aspects of the subject.

The second panel subject was, "The Doctor and 'Socialized Medicine.'" The subject was discussed by Dr. Maurice H. Friedman of Washington, D. C., and Dr. Louis H. Bauer, secretary of the World Medical Association.

Three Ohio Doctors Take Part in Secretaries, Editors Meet

The annual Conference of State Medical Association Secretaries and Editors held well-attended sessions on Sunday, November 28, and the following Monday morning, in connection with the Interim Session of the American Medical Association.

One of the key speakers on the program was Dr. Edward J. McCormick of Toledo, member of the Board of Trustees of the American Medical Association, who addressed members of the conference on the subject of medical legislation from the point of view of the Board.

Dr. McCormick also was one of the panel speakers in the conference on medical legislation.

Dr. Jonathan Forman, Editor of *The Journal*, was one of the principals in the conference on medical society radio programs. Dr. Forman discussed the subject, drawing upon his years of experience as a radio speaker.

Dr. Carll S. Mundy, Toledo, Fourth District Councilor, chairman of the Committee on Rural Health of the Ohio State Medical Association, and a director of Ohio Medical Indemnity, Inc., took a leading role in the conference on medical-hospital prepayment plans.

First A. M. A.-Sponsored P. R. Conference Excels

The first National Medical Public Relations Conference, held in connection with the Interim Session of the American Medical Association in St. Louis, passed all expectations for attendance and insured its becoming an annual event. The meeting was held on Saturday preceding the Interim Session.

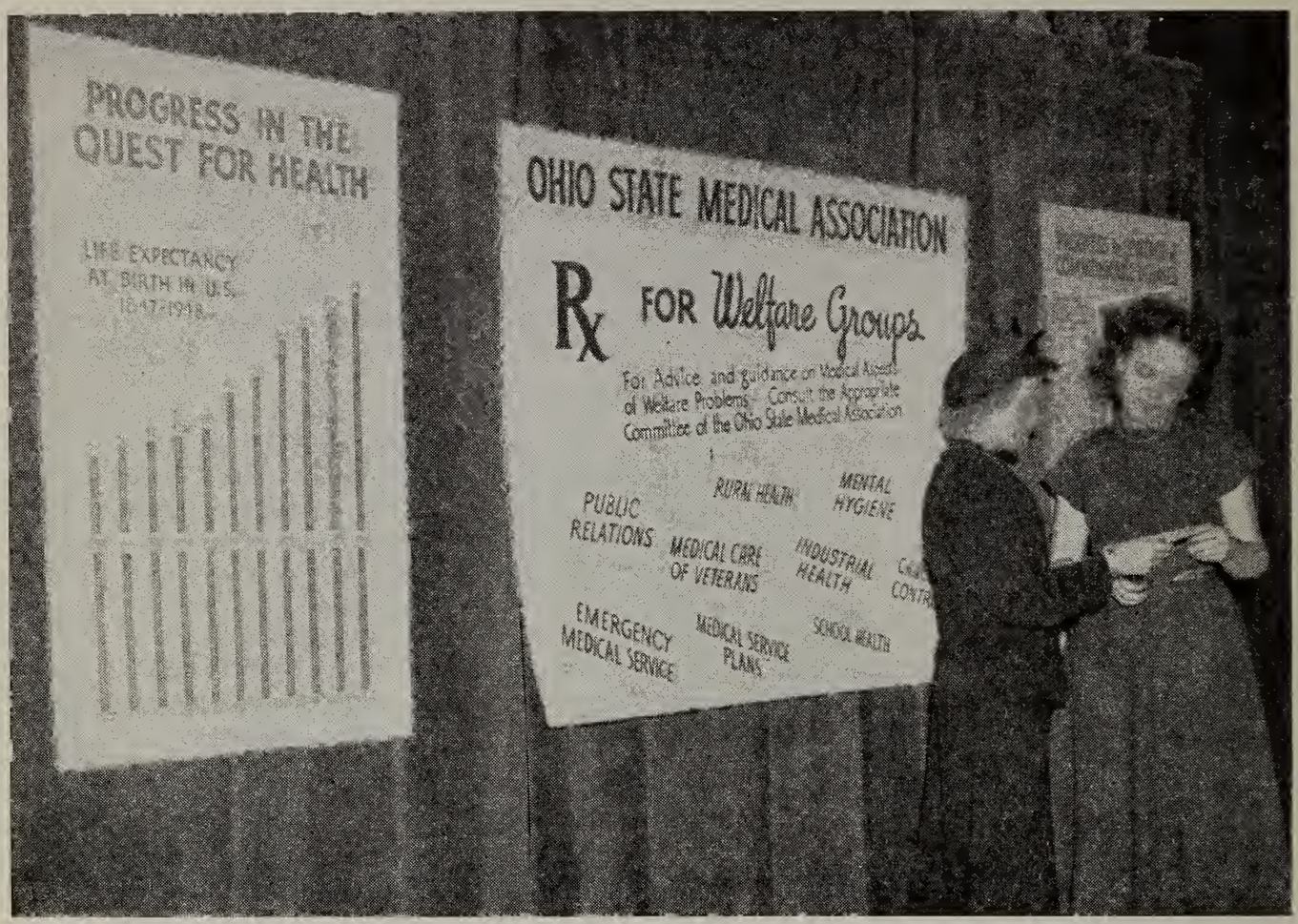
Representatives from state medical associations in 43 states and Hawaii attended. They included presidents, executive secretaries, public relations directors, and chairmen of public relations committees. In addition, 22 county societies and 19 related national organizations were represented. Registrations at the conference showed an attendance of 240.

The theme of the conference was "Common Targets in Medical Public Relations."

One of the highlight talks of the afternoon was by Clem Whitaker who told of his public relations firm's experiences in working with the California Medical Association in offering Californians a voluntary solution to their health care problems.

He told the conference: "Four years ago, only

Association's Exhibit at Ohio Welfare Conference



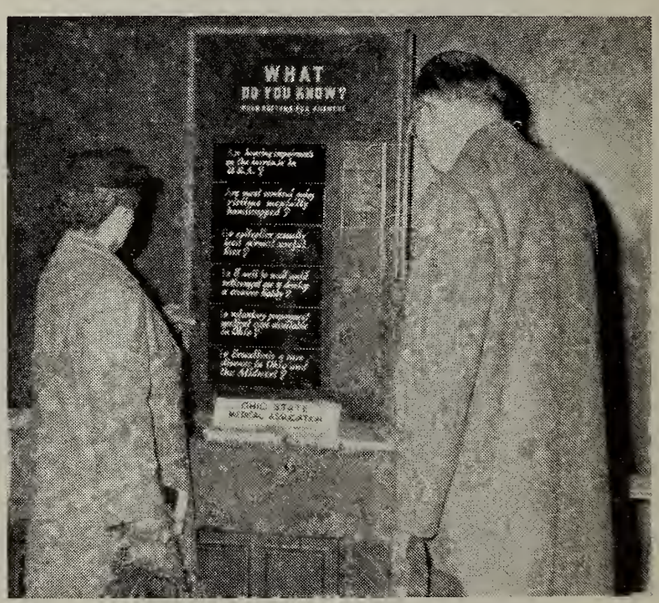
Shown above is part of the exhibit of the Ohio State Medical Association at the annual meeting of the Ohio Welfare Conference which was held at the Neil House in Columbus, November 13-17. Miss Mary Strawn, right, of the State Association Headquarters Staff, is explaining an O. S. M. A. booklet to a Conference visitor. O. S. M. J. staff photos.

about 2,500,000 California citizens were enrolled in voluntary health insurance plans. Today (as a result of California medicine's continuing educational campaign) there are more than 100 voluntary health insurance systems operating in California, with more than 5,000,000 insured members—a million more than Governor Warren promised to care for under his compulsory program."

Conger Reynolds, director of public relations for the Standard Oil Company of Indiana, told members of the conference that the relationship between the public and the medical profession may be reduced to an algebraic equation in which X plus Y equals good public relations. In the equation, X is a worthwhile produce or service and Y is telling the public about the produce or service.

"I think there is probably no business or profession that has less to atone for in failure to live right than does the medical profession," Mr. Reynolds said, "but I think there is probably no profession that has more to atone for in failure to tell the world of its doing."

Push Button Technique



Visitors at the Ohio Welfare Conference pushed buttons to obtain answers to health questions. This special "audience participation" equipment was part of the Association's exhibit. Health education literature which provided more detailed answers to the questions, was available on the table below the exhibit.

In Memoriam . . .

Conrad Stolzenbach Baker, M. D., Willimantic, Conn.; Yale University School of Medicine, 1934; aged 39; died November 13; former member of the Ohio State Medical Association in 1940 and 1941. Dr. Baker formerly had been connected with the Cleveland City Hospital and the Cincinnati General Hospital. Surviving are his widow, two children, his parents, a sister and a brother.

Robert Clifford Bingaman, M. D., Georgetown; Miami Medical College, Cincinnati, 1903; aged 70; died December 5; former member of the Ohio State Medical Association and the American Medical Association through 1918. Before his retirement, Dr. Bingaman practiced at Beaver. Surviving are his widow, a brother and two sisters.

Willoughby Dayton Bishop, M. D., Greenville; Ohio State University College of Medicine, 1913; aged 58; died December 7; member of the Ohio State Medical Association and the American Medical Association; president of the Darke County Medical Society in 1939 and its secretary-treasurer from 1931 through 1947. Dr. Bishop practiced medicine in Greenville for 34 years and for many years was city and county health commissioner. During World War I he served with the medical corps of the British Air Force He was active in fraternity organizations, being a member of several Masonic Orders, the American Legion and the Rotary Club. Surviving are his widow, a daughter, a sister and a brother.

William Hollis Bradford, M. D., Cleveland; University of Cincinnati College of Medicine, 1928; aged 47; died November 15; member of the Florida State Medical Association (according to latest A. M. A. Directory) and a Fellow of the American Medical Association. A veteran of World War I, Dr. Bradford spent most of his professional career with the Veterans Administration. He served at veterans hospitals in Dayton, Florida, Washington, D. C., and Pennsylvania before being assigned to Brecksville Veterans Hospital where he was chief medical officer and later manager. Surviving are his widow and one son.

Daniel Clarke Brennan, M. D., Akron; Harvard Medical School, 1912; aged 64; died November 28; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Summit County Medical Society in 1937 and a delegate to the O. S. M. A. in 1938. Dr. Brennan practiced in Akron for nearly 30 years. He was chief of staff at St. Thomas Hospital at one time; was a member of the Catholic Church and an officer in the Knights of Columbus. He also was a member of the Portage Country Club and the American Geriatrics Society. Surviving are his widow, five sons, a daughter, a sister and two brothers.

Charles Davis, M. D., New Holland; Eclectic Medical College of Cincinnati, 1892; aged 81; died November 14. Dr. Davis opened his office in New Holland in 1894 and continued his practice until a few days before his death. Surviving are his widow, a daughter, a sister and two brothers.

William P. Dupler, M. D., Crooksville; licensed to practice medicine in 1896; aged 83; died October 30; former member of the Ohio State Medical Association and the American Medical Association through 1935. Dr. Dupler practiced in Crooksville for 52 years, where he was a member of the Catholic Church. Surviving are a son and a daughter.

George Ray French, M. D., Andover; Western Reserve University School of Medicine, 1896; aged 75; died November 17; member of the Ohio State Medical Association and the American Medical Association; president of the Geauga County Medical Society in 1941. Dr. French was a native of Parkman, the son of Dr. and Mrs. John French. He formerly practiced in Mantua and Garrettsville, but for the past 35 years, until his retirement a few months ago, he practiced his profession in Burton. He was a member of several Masonic Orders and a member of the Congregational Church. Surviving are his widow and one sister.

John Cyril Hewgill, M. D., Akron; University of Toronto Faculty of Medicine, 1922; aged 51; died November 8; former member of the Ohio State Medical Association and the American Medical Association through 1945. Dr. Hewgill was a veteran of two wars, having served in the Royal Canadian Air Force during World War I and in the U. S. Army Medical Corps during World War II. Surviving are his widow, two daughters, his father, a sister and three brothers.

John Levoy Higbie, M. D., Jenera; Missouri Medical College, 1888; aged 85; died November 12; former member of the Ohio State Medical Association and the American Medical Association through 1945; vice-president of the Hancock County Medical Society in 1922. Dr. Higbie practiced his profession in the vicinity for approximately 60 years. At one time he was mayor of the village and served in other official capacities. Surviving are his widow, a daughter, a son and a brother.

Inez Lapsley, M. D., McAfee, Ky.; Laura Memorial Woman's Medical College, Cincinnati, 1901; aged 74; died November 19; former member of

the Ohio State Medical Association and the American Medical Association through 1940; member of the American College of Surgeons. Dr. Lapsley practiced in Cincinnati for nearly 40 years, until in 1940 she retired as a member emeritus of the staff of Christ Hospital. Surviving are three brothers and three sisters.

Sylvester M. Lynn, M. D., Ashtabula; Western Reserve University School of Medicine, 1889; aged 84; died December 5; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Ashtabula County Medical Society, 1921-22. Dr. Lynn came to Ashtabula in 1895 and continued his practice until his retirement about 10 years ago. He was a member of the Elks Club and the Knights of Pythias.

Robert Mehard Morrison, M. D., Youngstown; University of Pittsburgh School of Medicine, 1895; aged 75; died November 19; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American College of Physicians. Dr. Morrison practiced medicine in Youngstown for 54 years, during which time he was outstanding also for his civic and philanthropic work in the community. Prominent among his efforts was that of promoting funds for enlargement and improvement of the local hospital. Dr. Morrison was a member of several Masonic Orders, the Youngstown Club, Elks Lodge, and was a leader in the United Presbyterian Church. Surviving are his widow, a son, and a daughter.

William Alfred Ricard, M. D., Toledo; Toledo Medical College, 1906; aged 74; died December 4. Dr. Ricard practiced medicine in Toledo for 42 years. He was a member of a number of Masonic Orders and of the Sylvania Country Club. Surviving are his widow and two sisters.

Charles Dodge Slagle, M. D., Dayton; Starling Medical College, Columbus, 1897; aged 77; died December 21; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Slagle practiced for 40 years in Centerville until his retirement three years ago, when he moved to Dayton. He was a member of the Masonic Lodge, the Baptist Church and the Lyons Club. Surviving are his widow, four sons, including Dr. W. L. Slagle of Dayton, two daughters, two brothers and a sister.

Justin Miner Waugh, M. D., Cleveland; Columbia University College of Physicians and Surgeons, 1898; aged 76; died November 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Otolaryngology; member of the American Academy of Ophthalmology and Otolaryngology. Dr. Waugh was a charter member of the staff of the Cleveland Clinic and was head of the nose and throat department there from 1922 until his retirement in 1942. Surviving are his widow and a daughter.

Committee Named To Survey Medical Education

The Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges will sponsor a joint survey of medical education, beginning January 1, 1949.

Members of the committee of seven appointed to conduct the survey and publish a report of its finding are:

Dr. Alan Valentine, chairman, president, University of Rochester, N. Y.; Dr. Arthur C. Bachmeyer, associate dean, University of Chicago School of Medicine; Dr. Herman G. Weiskotten, dean, Syracuse University College of Medicine, Syracuse, N. Y.; Dr. Joseph C. Hinsey, dean, Cornell University Medical College, New York; Dr. Victor Johnson, director, Mayo Foundation for Medical Education and Research, Rochester, Minn.; Dr. Dean F. Smiley, secretary, Association of American Medical Colleges, Chicago; and Dr. Donald G. Anderson, Secretary, Council on Medical Education and Hospitals, American Medical Association.

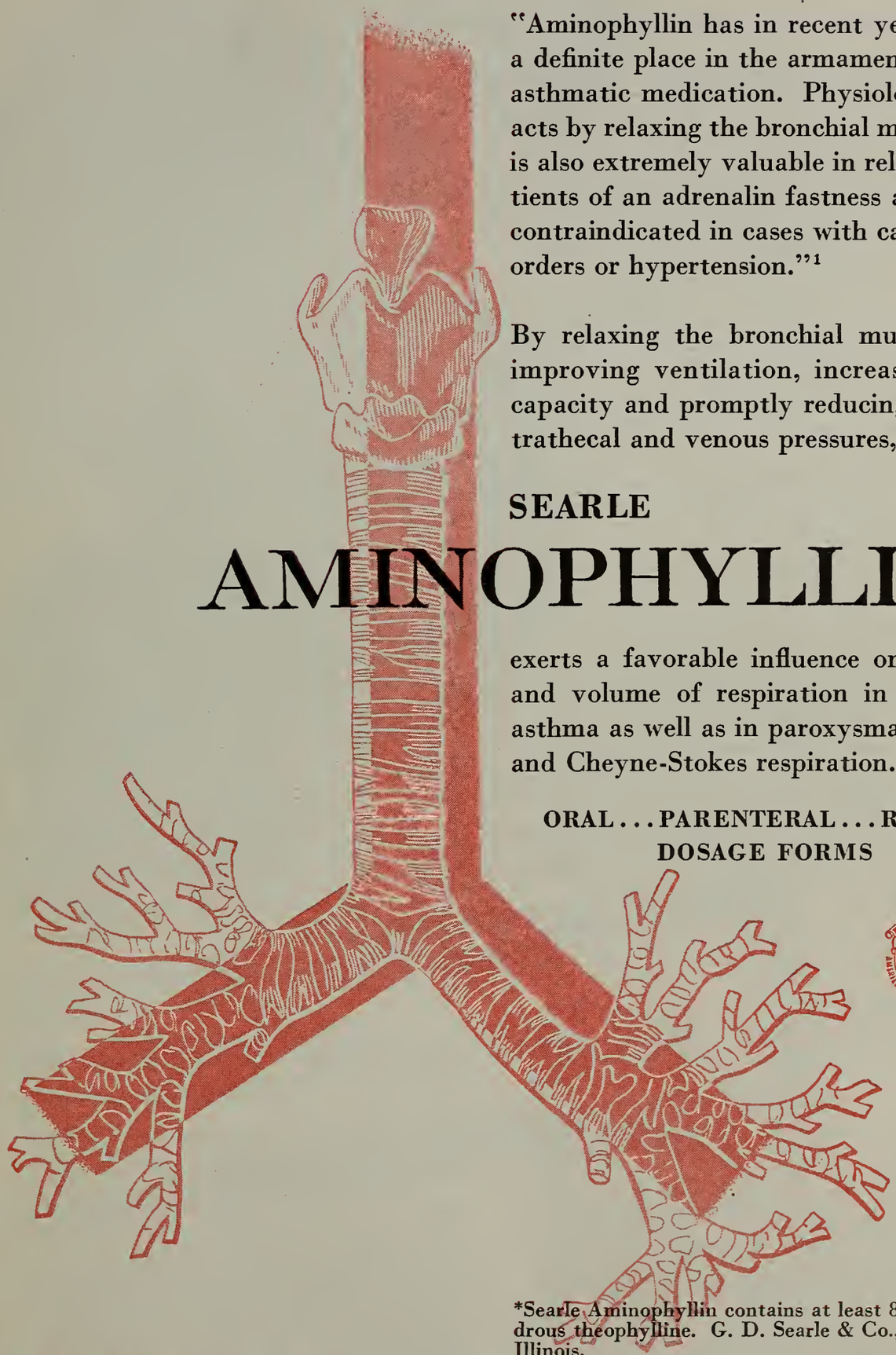
The committee announced that it had appointed Dr. John E. Deitrick, New York, to be the full-time director of the survey. Dr. Deitrick is a graduate of Johns Hopkins University School of Medicine. He is Associate Professor of Medicine at the Cornell University Medical College, and Medical Director and Director of Post-Graduate Instruction of the Second (Cornell) Medical Division, Bellevue Hospital, New York City.

The survey will extend over a period of three years.

The committee stated that the objectives of the study are to evaluate the present programs and determine the future responsibilities of medical education in its broadest aspects for the purpose of:

1. Improving medical education to better meet the over-all needs of the American people for the prevention of disease, the restoration, as far as possible, to health of all those who have suffered ill health or injury, and for the maintenance of the best standards of physical and mental health of all the people.
2. Assessing the degree to which medical schools are meeting the needs of the country for physicians.
3. Promoting the advancement of knowledge in the field of medical science.
4. Better informing the public concerning the nature, content, and purposes of medical education.

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*Searle Aminophyllin contains at least 80% of anhydrous theophylline. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Mountain, G. E.: Bronchial Asthma, J. Iowa M. Soc. *35*:324 (Aug.) 1945.

Medical Board Examinations . . .

Licenses To Practice Medicine and Surgery Sought by 70 Graduates; 13 Take Osteopathic Tests, While 147 Apply for Limited Practice

LICENSES to practice medicine and surgery in Ohio were sought by 70 medical school graduates at the examination of the State Medical Board, held in Columbus, December 13-15.

Thirteen applicants were examined in osteopathic medicine and surgery, including those taking the special examination and those seeking endorsement of licenses.

Examinations for certificate of limited practice were taken by 53 chiropodists, 20 mechanotherapists, 30 chiropractors, 37 masseurs and three cosmetic therapists.

Results of the examinations will be announced by the Board at a meeting to be held in Columbus on January 25.

Following are the written questions asked those who were examined for licenses to practice medicine and surgery:

ANATOMY

1. Outline the venous drainage of the brain and skull.
2. Outline the muscles of the eye, giving name, nerve supply and action.
3. Describe the sensory nerve supply of the hand.
4. Outline the sympathetic nervous system.
5. Name and describe the sinuses draining into the nose.

PHYSIOLOGY

1. The centers for what bodily functions are located in the medulla?
2. Discuss lactation in the human.
3. Discuss visual acuity.
4. What are the benefits and the dangers of cardiac hypertrophy?
5. What are the effects on body tissues resulting from the normal physiological action of the lungs?
6. Discuss the factors which determine the activity of the gastric glands.
7. Define or describe: (a) motor unit; (b) near-point of vision; (c) blood serum; (d) residual air; (e) nerve plexus.
8. Define: (a) myopia; (b) astigmatism. Indicate the type or kind of lens necessary to correct each of these defects.
9. Discuss the effect of the ingestion of fat on the activities of the gastro-intestinal tract.
10. What is the function of: (a) the turbinates; (b) the bicuspid valve; (c) the islands of Langerhans; (d) the labyrinth; (e) phagocytes.

BACTERIOLOGY

1. Give the life cycle of the trichina spiralis. How may its presence in an individual be detected?
2. What is Vincent's angina and describe the organisms suspected as its cause.
3. Give the laboratory procedures to be undertaken before a blood transfusion. Describe the reaction present indicating an unsatisfactory donor.
4. Give the method of detecting occult blood in the stools. What precautionary directions should be given the patient before obtaining the specimen for examination?
5. What is meant by the Rh factor in the blood and discuss its significance in child bearing.

DIAGNOSIS

1. Describe symptoms and signs of spastic paraplegia.
2. Differentiate ruptured vein in esophagus, bleeding stomach ulcer, and hemorrhage from the lungs.
3. How long after infection do spirochaeta pallida remain in the blood stream and name three stages of syphilis.
4. What are high and low normal BMR readings in thyroid activity tests? What is a toxic adenoma of the thyroid?
5. Give signs and symptoms of Froelich's syndrome.
6. Give physical findings in extreme congestive heart failure.
7. Give signs and symptoms of subarachnoid hemorrhage.
8. Differentiate acute appendicitis, intussusception and sudden obstruction of small bowel.
9. Differentiate Vincent's stomatitis, leukoplakia, and pemphigus of oral cavity.
10. Differentiate herpes zoster, pleurodynia and arthritis of sterno costal articulation.

CHEMISTRY

1. Discuss the mechanisms by which, in a healthy individual, the content of the glucose in the blood is maintained at approximately a constant level.
2. Discuss the chemical nature and the properties of three of the following substances: (a) alkaline phosphatase (blood serum); (b) sulfonamide; (c) uric acid; (d) acetone; (e) bilirubin.
3. By what experimental procedure has our knowledges of the chemical origin and function of the hormone of the thyroid gland been increased in recent years? Discuss.
4. Describe a test whereby one could differentiate between an obstructive jaundice and a nonobstructive jaundice.
5. Give the hydrogen ion concentration of: (a) cerebrospinal fluid; (b) what variation, if any, occurs in tubercular meningitis?

MATERIA MEDICA AND THERAPEUTICS

1. Name the drug of choice and give dosage: (a) Auricular fibrillation caused from chronic rheumatic heart disease. (b) Auricular fibrillation caused from thyroidtoxicosis.
2. Name two drugs used as anti-coagulants. Upon what phase in the mechanism of coagulation do they exert their action?
3. Draw a diagram over a thirty-six hour period giving the action of protamine zinc insulin, regular insulin and globulin insulin on the blood sugar curve.
4. Write a prescription for a drug used in pulmonary dyspnea, etiology of which is neurogenic. Give mechanism of its action.
5. What are the duties of the physician in cases of poisoning?
6. In anesthesia with ether, compare the objective findings in the anesthetic stage and in the paralytic stage.
7. Compare the mechanism of action of iodides and propylthiouracil in thyroidtoxicosis caused from hyperplasia of the thyroid gland.
8. How would you determine the potency of liver extract used in the treatment of a case of pernicious anemia?
9. Give the mechanism of the anti bacterial action of the sulfonamides.
10. Name two respiratory stimulants, mode of administration and dosage.

PRACTICE

1. Give the etiology and symptoms of chorea.
2. Discuss the clinical course and complications of emphysema.
3. Give the etiology and symptoms of pulmonary tuberculosis.
4. Give the etiology and complications of Brucellosis.
5. Give the etiology and symptoms of diphtheria.

PATHOLOGY

1. Describe the changes in kidney structure in advanced arterio sclerotic nephritis and discuss their relation to the alteration in urinary secretion.
2. Describe the conditions found in the heart at autopsy after death from heart failure associated with vascular hypertension and discuss reasons for such failure.
3. Discuss the different pathologic conditions that may cause hemiplegia. What condition in the cerebral circulation may cause a merely temporary or transient paralysis?
4. Describe the pathology present in a case of poliomyelitis causing (a) paralysis in only one extremity (one leg); (b) in a case where the involvement is such as to require the use of an "iron lung."
5. Discuss the usual cause and pathology of a tubo-ovarian abscess.
6. What is meant by vitamin deficiency? Give three



Throughout the formative years . . .

From birth to at least the age of 14 years, investigators now agree children are susceptible to rickets, with scarcely diminished frequency.[1]

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1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am: Jour. Dis. Child.*, 66:1, July, 1943.
2. Stearns, G.: *Jour. Lancet*, 63:344, Nov., 1943.

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HAVE YOU PAID YOUR 1949 DUES?

Have you paid your 1949 local and Ohio State Medical Association dues to your County Society Secretary-Treasurer?

If not, this should be done immediately, so that your local Secretary-Treasurer can forward the State Association dues to the Columbus office.

Dues are payable on or before January 1 annually. Membership in the State Association is on a calendar year basis. Dues must be paid promptly to keep your membership from lapsing.

This is important. Don't delay. The 1949 State Association dues are $15.00.

examples with brief descriptions of the morbid changes occurring.

7. What is pulmonary empyema? Give the usual causes, describe the conditions present in a typical case and possible results.
8. Name three diseases which may result from drinking contaminated water and describe briefly the intestinal lesions which may be present in each.
9. What conditions result from Hook-worm infestation and what measures of prevention may be advised?
10. What pathology may result from benzine poisioning? In what industries may it occur?

SURGERY

1. Outline the treatment of a patient with a second degree burn of the abdomen, thorax, face, and hands.
2. Discuss the etiology, diagnosis, and treatment of perinephritic abscess.
3. Discuss the etiology, pathology, prophylaxis, and treatment of gas gangrene.
4. Give the symptoms and possible complications of fracture of the pelvis. Outline briefly the treatment of (a) an uncomplicated case, and (b) the most common complication. (Omit operative technic).
5. Describe the displacement of the proximal fragment in fracture of the shaft of the radius in (a) the upper third; (b) midshaft; (c) lower third. Describe the method of reduction and position of splinting of each site.

OBSTETRICS AND GYNECOLOGY

1. Discuss etiology, symptoms, and treatment of cystocele.
2. Describe the anatomical supports of the uterus. (b) What conditions must be fulfilled before forceps are applied?
3. Give etiology, symptoms and treatment of femoral thrombophlebitis.
4. How would you deliver a frank presentation?
5. Discuss the care of the premature infant.

SPECIALTIES

1. Discuss cause, symptoms, and treatment of mastoiditis.
2. Describe and give treatment of dermatitis venenata.
3. Define the following: (a) Glaucoma; (b) Otitis media; (c) Nystagmus.
4. Give symptoms of poliomyelitis.
5. Describe stages of ether anesthesia.

PREVENTIVE MEDICINE AND HYGIENE

1. Name five diseases transmissible to man by insects, name the vector in each disease and tell how each is preventable.
2. Name five diseases transmissible to man by animals and the way to prevent transmission.
3. What diseases are reportable to the Board of Health under Ohio laws? What certification by a physician is required by Ohio law before a marriage license can be issued?
4. What are the essential points to be considered and checked in the inspection of dairies processing milk for human consumption?
5. For what length of time does immunity continue after vaccination or immunization is done against: (a) smallpox; (b) diphtheria; (c) tetanus; (d) pertussis; (e) typhoid fever.

Buckeye News Notes . . .

Canton—Dr. Sidney Larson recently accepted an appointment as member of the board of directors of the Stark County Tuberculosis and Health Association.

Cincinnati—Two physicians, Dr. George M. Guest and Dr. Samuel N. Rapoport, received Presidential certificates of merit for their contributions while in military service. Dr. Guest received his citation for his service with the Committee on Medical Research in Washington, D. C. Dr. Rapoport received his certificate for his discovery in the field of whole blood preservatives.

Cincinnati—Dr. Clyde S. Roof has been elected chief of staff of the Bethesda Hospital medical staff for the coming year to succeed Dr. Albert L. Haas. Other staff officers are Dr. T. Brent Wayman, vice-president, and Dr. Huston H. Rinehart, secretary.

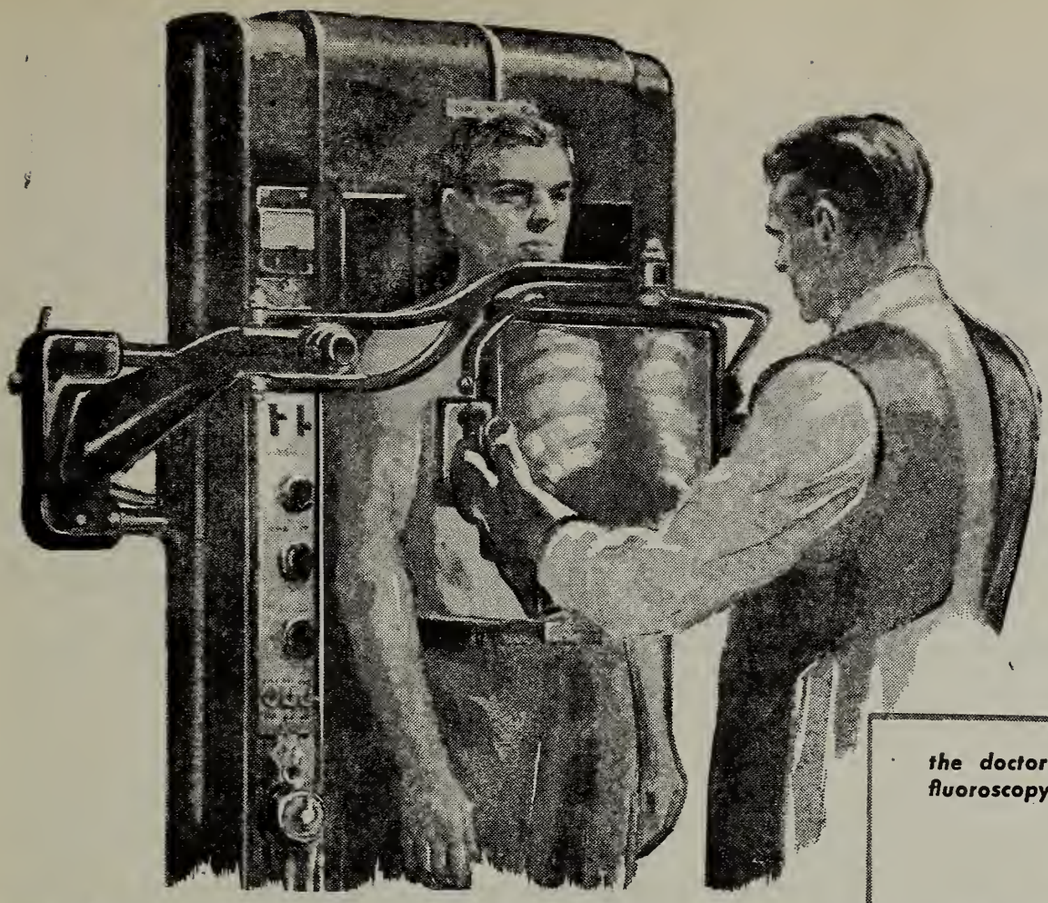
Cincinnati—Dr. Erwin C. Binstadt addressed the November meeting of the Cincinnati Employment Managers Club on the subject: "The Place of Industrial Medicine in Personnel Relations."

Columbus—Dr. Donald F. Bowers acted as chairman of the annual Fini la Guerre banquet, sponsored by the War Veterans Republican Club, in mid-December.

Columbus—Dr. Russel G. Means, Ohio State University College of Medicine, was placed on a committee to nominate officers for the American Hearing Society. He also was appointed to fill the unexpired term of Dr. George Harding as a trustee to the Franklin County Tuberculosis Hospital and Clinic.

Dayton—Dr. Charles A. Dille discussed the Rh factor at a meeting of the Dayton Chapter, Ohio Society of Medical Technologists in November.

Ironton—Dr. Ralph L. Phillips of Friendship related experiences in the Pacific during the war before a November meeting of the local Rotary Club.



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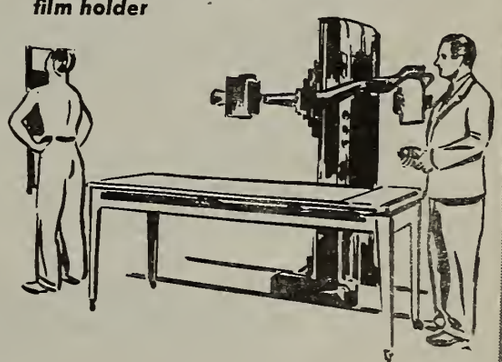
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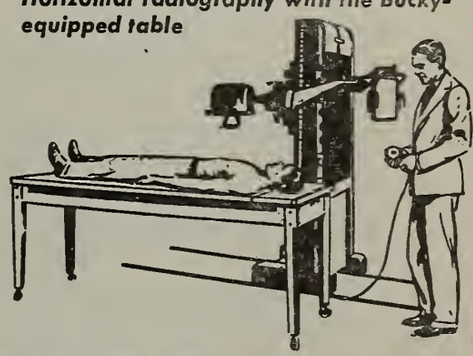
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHAT'S FAIR FOR ONE IS FAIR FOR ALL

Action of the American Medical Association in deciding to present a nation-wide educational campaign which will carry directly to the people the views and policies of the medical profession on legislative, as well as other vital current issues, has caused a furore in some quarters.

Mr. Oscar Ewing, Federal Security Administrator, who is plugging day and night for the enactment of a compulsory health insurance program, has used such terms as "war chest," "hierachy," "panicky" in referring to the action of the A. M. A. for raising funds for the proposed educational campaign and has expressed the belief that "it would be better if the A. M. A. spent this 'educational fund' enlightening some of its own backward members."

In an address to the State and Territorial Health Officers, gathered in Washington, D. C., Ewing intimated that he is expecting them to spearhead a drive in every community to win the favor of the people for his government health plan and to rally support from organizations of all kinds, etc., etc.

Caustic criticism has been hurled at the A. M. A. and the medical profession by many of the known advocates of the Truman-Ewing scheme, including Congressman Dingell, of W-M-D Bill fame, and Dr. Channing Frothingham, whose Committee for the Nation's Health has been circulating the country with literature, castigating the A. M. A. and propagandizing for national health insurance.

From still other quarters have come loud wails about the "medical lobby," demanding an investigation of it and the "huge" sums it has been spending.

Apparently, those who are belching vituperative comment regarding the medical profession's determination to go to the people also with its views on the issues are holding to the theory that what's fair for one is unfair for others.

Showing remarkable incónsistency, the Federal Security Administrator apparently sees nothing obnoxious in his practice of spending a big chunk of the people's cash in promoting his pet schemes. Of course, what he plans to spend in the future to carry the message to the people will be securely hidden in the lush budget which he will ask the Congress to approve.

Again demonstrating remarkable inconsistency, Mr. Ewing thinks the action of the A. M. A. in asking its members to finance a program of public education is stinko but at the same time apparently sees nothing wrong in his request to the public health officials of the country, all of whom are paid from tax funds, that they give their time and effort to promoting his controversial program.

Turning to another sector from which poison darts have been hurled at the A. M. A., one might ask how much to date Dr. Frothingham and his committee have spent in their propaganda campaign for national health insurance? Why should they be so incensed at the action of the A. M. A.?

Moreover, the record will show that a few Congressmen haven't been at all backward in using their franking privilege to distribute similar propaganda and that certain labor organizations admittedly spent far from the cost of chicken feed in carrying their message to the people prior to the November 2 election; and are still at it, preparatory to the forthcoming session of Congress and with an eye on the Congressional elections in 1950.

As Mr. Ewing admits, the people are going to decide the issues. That being the case what's wrong in giving the people both sides of the issues? The members of the medical profession would be chumps to let the case go by default and, in our opinion, the people would rate them as that if they did so.

No, Mr. Ewing, your "backward" medical profession is not going to sit out this one. It's going to tell the people the facts about medicine's contributions and about the advantages to them of a free American system of medical and health services.

It's going to assume that what's fair for one is fair for all when it comes to enlightening the people.

WHY THE WHOLE PROFESSION'S BEHIND THE EIGHT BALL

Here are a few scattered quotations from the press which reveal why the public relations of the medical profession is in need of improvement and why some casual observers at times think a governmental medical plan might not be so bad after all:

"A neighbor of mine collapsed on a porch in a nearby town. Four doctors were called before one would respond."

"The board (hospital board) said that with the exception of emergency cases all patients must pay in advance or make satisfactory credit ar-

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...if smokers are affected by the irritant properties of cigarette smoke

Sometimes physicians may advise "Don't smoke at all." But even where that is indicated, how many patients will forego the pleasure of smoking?

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Perhaps you too will find it advisable to suggest to your patients who smoke . . ."Change to Philip Morris."

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****Reprints on Request:*

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

rangements." (The author of that statement needs a postgraduate course in how to meet the public.)

"Soured by frequently exorbitant surgical fees, the tendency of charging whatever the traffic will bear, on the part of some unscrupulous physicians, a growing feeling that medical practitioners are becoming more dedicated to their ledgers than to humanitarian motives, and worried—if neither very rich nor very poor—lest a severe illness or injury in the family result in economic crippling, much of the public sees great value in some form of health insurance made universally available."

Admittedly, the situations cited are of the isolated variety. Nevertheless, these are some of the questions which will be shot at the medical profession, again and again, as it carries its case to the people during the coming months.

The medical profession and no one else has discovered a universal solvent for a professional chiseler.

At the same time more members of the profession are going to have to wake up to the fact that their patients are human and intelligent enough to differentiate between satisfactory treatment and the brush-off. One other thing they must realize: The people are going to decide what kind of medical practice they want in the future and their decision will be based largely on an analysis of what they are getting now.

VICIOUS CIRCLE IN FIELD OF TAXATION

Here's one for the experts to figure out.

Frank Bane, executive director of the Council of State Governments, in a talk at the recent health commissioners conference in Columbus, pointed out that the states are asking the Federal Government to get out of certain fields of taxation so they can use such taxing authority to replenish their treasuries. The answer the states get from Washington is if the states will quit asking for Federal handouts, grants and subsidies, Uncle Sam will give up some of the tax fields he has pre-empted.

Thus, you have the vicious circle. Where should the first move be made? In our opinion, the states should move first. By doing so they may find that activities will be carried on more efficiently and economically if state and local funds are used. Certainly the state agencies are closer to the grass roots, assuring a closer check on how funds are spent, what funds are needed, and what kind of performances are being registered. At any rate the shift from local and state responsibility to Federal responsibility should be stopped.

GOOD LEADERS SELECTED BY NEW GENERAL ASSEMBLY

In our opinion the 98th Ohio General Assembly, convening January 3, will be in the hands of extremely capable leaders.

For the first time in the history of the Ohio Senate the president pro-tem (majority party leader) will be a woman—Senator Margaret A. Mahoney, Cleveland. In selecting Miss Mahoney as their floor leader, the Democrats of the Senate conferred a well-deserved honor on an intelligent, experienced and aggressive legislator. During her previous terms in the House and the Senate, Miss Mahoney established a splendid record and demonstrated her ability to handle the important post assigned to her by her colleagues. It will be remembered that Miss Mahoney authored the enabling act for medical service plans sponsored by the Ohio State Medical Association and enacted by the General Assembly in 1941. She is sincerely interested in medical and health legislation and her views on such questions always have been sound and constructive.

Selection of John F. Cantwell, Youngstown, experienced Democratic member of the House of Representatives, as Speaker also was a ten-strike, in our opinion. Mr. Cantwell served during the last session of the Legislature as minority floor leader and demonstrated that he is capable of carrying the vital responsibilities which accompany the office of Speaker. He, too, always has taken a constructive and sound viewpoint on medical and health proposals during his previous four terms in the House.

The Democratic floor leader in the House will be A. G. Lancione, Bellaire, who built a good record for himself in the legislative session of 1947-48, and who can be counted upon to give representatives of the medical profession a fair, courteous hearing on pending proposals.

The Republican (minority) floor leader of the Senate will be Senator Roscoe R. Walcutt, Columbus, a Senator with three previous terms, and one of the outstanding members of the upper house during his legislative career. Senator Walcutt always has been exceedingly sympathetic to the views and suggestions of the medical profession.

Former Speaker C. William O'Neill, Marietta, will take over the post of minority floor leader of the House. Had the election produced a Republican majority in the House, O'Neill undoubtedly would have been re-elected Speaker, a post in which he made an exceptionally fine record during the session of the Ninety-Seventh General Assembly. Mr. O'Neill's attitude on medical and health questions has been good and the medical profession received cooperation from him on many occasions in the past.

The official count shows that the party standings in the Senate will be 19 Democrats and 13

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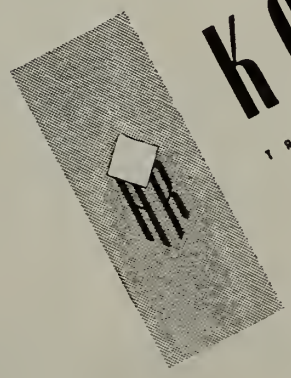
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Republicans; the House, 69 Democrats and 66 Republicans, meaning there will have to be a crossing over of party lines to insure the enactment of emergency legislation.

Although the leadership in both houses will be in the hands of experienced and capable members, the General Assembly as a whole will have many new faces. Some of these will be "unknowns" as to their views on pending measures, and some, through lack of experience, will be unfamiliar with crack-pot proposals. This may make the job of the leaders more difficult than usual. Also, it means that legislative committeemen of many county medical societies will have to make a special effort during the present legislative session to keep in close touch with their Representative and Senator, to insure that both will have accurate and proper information on all bills relating to medicine and health.

AN IMPORTANT WORK WHICH MUST GO ON

H. C. Ramsower, who is retiring as director of the agricultural extension service in Ohio, has given assurance that he does not intend to lose interest in activities designed to improve health conditions among the rural population of Ohio.

To persons who have served with Mr. Ramsower on the Ohio Rural Health Committee, and others, this will be welcomed news. He has done much to bring about a coordination of interests and activities of farm groups, the medical profession and other organizations concerned with the health and medical problems of rural areas. The job has just been started. There must be no lessening of efforts toward achieving the objectives which have been set. The medical profession of Ohio has pledged its active support and leadership to the work which Mr. Ramsower and his associates initiated and are carrying on.

GIVE THE YOUNGER MEN A REAL WELCOME

"I wonder if we are not often guilty of being negligent in regards to courtesy and understanding towards younger men in our own profession. It is easy to forget how much a kind word or an expression of real interest by an older physician meant to us when we were starting our own professional careers. . . . Let's give the younger men a real welcome."

This is an observation made by Dr. Edward D. Anderson, president, Hennepin County Medical Society, Minneapolis.

Think it over. Dr. Anderson has scored a point.

"THE DEAN" WILL BE MISSED, BUT NOT FORGOTTEN

After 35 years as a member of the State Medical Board, Dr. J. H. J. Upham is retiring from the board, at his own request. To say that "the Dean" will be missed in activities coming within the jurisdiction of the Board is putting it mildly.

Dr. Upham, and his close friend and colleague, Dr. Herbert M. Platter, long-time secretary of the Board, have contributed more to making Ohio's medical examining and licensing system outstanding among those of the various states than any other persons, past or present. Many physicians now in practice owe both of them a large debt of gratitude for the sage advice and constructive guidance which they have given to so many young physicians over a period of many years. The people of Ohio should be eternally grateful to them for the battles which they have fought year after year to maintain and improve the medical and health standards of this state.

As he gives up another assignment in the line of duty on behalf of the people and the medical profession, Dr. Upham will have the satisfaction of knowing that he has added more to his outstanding record of jobs well done and of great value to the public, as well as his own profession.

NO PLACE FOR EXPEDIENCY AND EMOTIONAL APPEAL

Doubtless there will be some physicians among the displaced persons who will be brought to the United States under the special legislation enacted by the Congress, and some of them will have considerable difficulty meeting the medical licensure laws of the various states. This probably will stimulate action from some circles for relaxation of the requirements of the state licensing laws.

Even though the people of this country may be sympathetic to the situations which now confront the displaced persons, they should be warned against the lowering of medical licensure standards. They should be told about the situation abroad where the medical schools are in a deplorable condition and have been for a decade; where even physicians in practice know little or nothing about the newest advances in scientific medicine because they have been shut off from the rest of the world. Moreover, they should be impressed with the fact that the licensing laws were enacted to protect the public against unqualified and incompetent practitioners; that making exceptions would lead to a deterioration of medical education, medical practice, and health standards in this country.

This assuredly is a question which must be considered without resort to emotional appeals. The protection of the American public must have first priority.

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SEYMOUR... ...INDIANA

Do You Know? . . .

The Carroll County Medical Society with nine members was the first society in the state to send in 1949 state dues for 100 per cent of its membership. Dr. Charles H. Dowell, Carrollton, is the secretary.

* * *

The number of narcotic addicts in the nation has dropped from between 150,000 and 200,000 persons in 1914 to an estimated 48,000 persons in 1948, according to three physicians from the United States Public Health Service hospital in Lexington, Ky., writing in the Dec. 4, issue of the *J. A. M. A.*

* * *

There are now 160 local public health departments in Ohio. Of this number, 70 are full-time units, serving approximately 75 per cent of the state's population.

* * *

The Committee to Survey Medical Education has announced the appointment of Dr. John E. Deitrick of New York as the full-time director of the survey of medical education being sponsored by the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges.

* * *

The Association of State and Territorial Health Officers meeting in Washington, D. C., Nov. 14-17, adopted a number of resolutions pertaining to the expansion of local public health services throughout the country, but took no action on national health insurance.

* * *

Dr. George N. Papanicolaou, New York, has been awarded the Borden Prize for outstanding contribution by a faculty member of an American medical college in the field of medical science.

* * *

Dr. W. Wendell Green, Toledo, is the new secretary of the American Proctologic Society.

* * *

All seven doctors of medicine who were members of the House of Representatives in the 80th Congress were re-elected. They are: (Republicans) Drs. Ivor D. Fenton, Pennsylvania; Walter Judd, Minnesota; A. L. Miller, Nebraska; and Frederick C. Smith, Ohio; (Democrats) E. H. Hedrick, West Virginia; Thomas E. Morgan, Pennsylvania; and Joseph L. Pfeifer, New York.

* * *

The Chicago Medical School has been admitted to the list of medical schools approved by the Council on Medical Education and Hospitals of the American Medical Association, effective Nov. 9, 1948. This action does not apply to students who completed their formal academic education at the school prior to that date.

* * *

Dr. Edward A. Gall has been appointed to the vacant Mary M. Emery chair of pathology at the University of Cincinnati College of Medicine, and director of the Department of Pathology at Cincinnati General Hospital. He succeeds the late Dr. Richard S. Austin.

* * *

The title of President Emeritus of the International College of Surgeons has been bestowed on Dr. Andre Crotti, Columbus. He was president of the group in 1941-42, and president of the United States chapter in 1939-40.

* * *

Dr. Louis Mark, Columbus, is the new president of the American Contract Bridge League, which has a membership of over 20,000 of the leading bridge players in the country.

* * *

The Alumni Achievement Award of the Ohio State University College of Medicine has been presented to Dr. Russel G. Means, Columbus, "in recognition of outstanding professional attainment and distinguished service to mankind through an unswerving devotion to the highest ideals in the practice of the art and science of medicine."

* * *

The American Foundation for High Blood Pressure has made a grant of $5,000 to the Department of Anatomy of the Western Reserve University School of Medicine. The grant will be used for research on arteriosclerosis as a complication of diabetes.

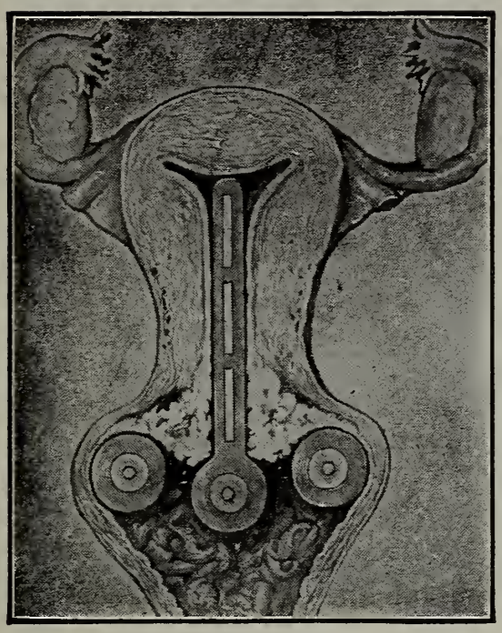
* * *

The American Nurses' Association estimates that in the summer of 1948 there were approximately 435,000 registered nurses in the United States. Of this number, 64 per cent, or about 280,500 were active in nursing. Of the 36 per cent inactive professionally, homemaking is a full-time occupation for slightly more than four out of five nurses.

* * *

Dr. Harold N. Cole of the Department of Dermatology and Syphilology, Western Reserve University School of Medicine, recently delivered the first Alembert Winthrop Brayton Foundation address at a meeting of the Academy of Medicine of Indianapolis. His subject was "The Antiquity of Syphilis With Some Observations on Its Treatment Through the Ages."

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Selective Service . . .

Methods of Handling Deferment of Medical and Premedical Students Outlined; Ways Devised to Minimize Time of Medical Advisors

SEVERAL directives of interest to the medical profession have been issued by the National Headquarters and the Ohio Headquarters of Selective Service.

A bulletin issued by the National Selective Service Office (Local Board Memo No. 7) relating to deferment of students of the healing arts, reads in part as follows:

HEALING ARTS ADVISORY COMMITTEE

"A Healing Arts Educational Advisory Committee has been established by the Director of Selective Service . . .

"The purpose of this committee is (1) to recommend to the Director of Selective Service means by which sufficient personnel may be trained in the professions of the healing arts, through the maintenance of an adequate flow of students through professional and preprofessional schools; (2) to recommend procedures by which an adequate flow of students through the professional schools might be maintained to meet the nation's needs in trained medical, dental, veterinary and osteopathic personnel; and (3) to advise the educators in the fields of the healing arts professions on problems arising through the operation of the Selective Service Act of 1948.

STUDENTS IN PROFESSIONAL SCHOOLS

"The committee has advised the Director of Selective Service that the national interest will require graduates of medicine, dentistry, veterinary medicine and osteopathy annually in numbers equal at least to the present level. It recommends that students properly enrolled in the professional schools of these four professions and satisfactorily pursuing full-time courses leading to graduation, should be permitted to continue their studies until graduation.

STUDENTS IN PREPROFESSIONAL SCHOOLS

"This Committee also recommends that sufficient numbers of preprofessional students should be made available to maintain the freshman classes of these professional schools at present levels. To accomplish this the Committee recommends that these professional schools select provisionally for admission, upon completing the preprofessional course to the satisfaction of the professional school, certain students who have satisfactorily completed at least one year of the preprofessional course. These provisional admissions will continue valid until the following July 15 unless cancelled by the professional school.

"The number of preprofessional students who are not otherwise deferrable and who have completed at least one year of preprofessional work and who may be selected, is, for the freshman class of 1949, 55 per cent of the 1948 freshman professional class; for the freshman class of 1950, 62½ per cent of the 1948 freshman professional class; and for the freshman class of 1951, 100 per cent of the 1948 freshman professional class.

"These percentages of provisional admissions are to be reviewed by the Committee once each year and recommendations as to the numbers will be adjusted for the ensuing classes, in accordance with the demonstrated needs at that time. These recommendations will be available early enough to permit the review of individual provisional admissions by the professional schools prior to July 15.

IDENTIFICATION OF STUDENTS

"In order to identify to selective service local boards the professional students of medicine, dentistry, veterinary medicine and osteopathy, and the preprofessional students who have been provisionally admitted to the professional schools, the Committee has recommended that an authorized representative of the professional schools should submit, on a form designed for that purpose, (1) the names of professional students who are not otherwise deferrable under the Selective Service Act of 1948 and who have duly matriculated in their professional schools and are actually pursuing a course leading to graduation in one of the specified professions; and (2) the names of preprofessional students who have completed at least one year of preprofessional study and have been provisionally accepted for entrance into the professional school upon completion of a preprofessional course to the satisfaction of the professional school.

CERTIFICATION OF STUDENTS

"The form to be used by the professional schools will be Certification of Preprofessional and Professional Students of Medicine, Dentistry, Veterinary Medicine, and Osteopathy (SSS Form No. 103). All such certificates will be issued to local boards through National Headquarters and State Headquarters for Selective Service, and will constitute evidence in support of the student's claim for occupational classification. Before issuing a certificate for a preprofessional student, the professional school should secure

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OBSTETRICS AND GYNECOLOGY

A full time course. In Obstetrics; Lectures; pre-natal clinics; witnessing normal and operative deliveries; operative obstetrics (manikin). In Gynecology: Lectures; touch clinics; witnessing operations; examination of patients pre-operatively; follow-up in wards postoperatively, Obstetrical and Gynecological pathology. Anesthesia. Attendance at conferences in Obstetrics and Gynecology. Operative Gynecology on the cadaver.

For the GENERAL PRACTITIONER

Intensive full time instruction in those subjects which are of particular interest to the physician in general practice. consisting of clinics, lectures and demonstrations in the following departments—medicine, pediatrics, cardiology, arthritis, chest diseases, gastroenterology, diabetes, allergy, dermatology, neurology, minor surgery, clinical gynecology, proctology, peripheral vascular diseases, fractures, urology, otolaryngology, pathology, radiology. The class is expected to attend departmental and general conferences.

EYE, EAR, NOSE AND THROAT

A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology; physiology; neuro-anatomy; anesthesia; physical therapy; allergy; examination of patients pre-operatively and follow-up post-operatively in the wards and clinics.

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assurance from the student that he will not obtain a similar certificate from another professional school.

IF A STUDENT FAILS

"When a student fails to pursue his course in a manner which is satisfactory to the professional school, an authorized representative of the school will cancel the Certification of Preprofessional and Professional Students of Medicine, Dentistry, Veterinary Medicine, and Osteopathy (SSS Form No. 103) for such student and will notify the local board of such cancellation, through National Headquarters and State Headquarters of Selective Service."

REGARDING MEDICAL CONSULTANTS

Two bulletins issued by the Ohio Selective Service Headquarters, following consultation with representatives of the Ohio State Medical Association, relate specifically to the functions and responsibilities of medical advisors to local Selective Service Boards.

These directives clarify confusion which has arisen regarding the duties and responsibilities of medical advisors and definitely limit the amount of time and service which each medical advisor will be expected to give to medical questions which arise.

These Local Board memoranda (Memo No. 24 and Supplement to Memo No. 24) read in part as follows:

"A very large percentage of registrants in the upper age brackets now being considered have, at some time prior to the passage of the Selective Service Act of 1948, been rejected for service in the armed forces. . . .

"It is necessary to reduce the numbers of unacceptable registrants reporting for examination by every means possible under present regulations.

WHAT BOARD CAN DO

"(a) The local board may presume that any registrant remains disqualified for service who has at any time been rejected or discharged by any of the armed forces as physically or mentally disqualified for service, unless and until the local board decides that the registrant may be acceptable to the armed forces. Some of the facts that may cause the local board to reach this conclusion are:

"(1) Information from the file of the registrant in the Records Depot;

"(2) Findings of the medical advisor to the local board after interview of the registrant;

"(3) Miscellaneous sources by which the local board is convinced that the registrant may now be acceptable to the armed forces;

"(4) The possibility that a registrant rejected for service in the armed forces has recovered from the disqualifying defect. Whenever such recovery is indicated, or the local board has reason to believe that the defect no longer exists, the registrant should be forwarded for armed forces physical examination. This action is a procedure authorized under the provisions of Section 623.12 of the Regulations.

TO MINIMIZE WORK OF MEDICAL ADVISOR

"To minimize the time and work of Medical Advisors to local boards and to carry out the intent of the regulations providing for the appointment of Medical Advisors, each local board should comply with the following procedures whenever feasible:

"1. Services of the Medical Advisor should be used only for the purposes enumerated in the Selective Service Regulations and the Manual for Medical Advisors. He should be called upon for advice and guidance in classifying registrants claiming disqualifying defects and conditions and on general medical matters which may arise. On the other hand, he should not be called upon to make physical examinations of registrants.

WHEN IN DOUBT

"2. When in doubt as to whether a physical or mental defect claimed by a registrant is included in the list of disqualifying obvious defects or manifest conditions listed in Part 629 of the Selective Service regulations and appearing in paragraph 11 of the Manual for Medical Advisors and further implemented in Army Regulations 40-115, the local board should seek the advice of the Medical Advisor.

"3. If the local board decides, after consultation with the Medical Advisor, that the defect claimed by the registrant is not included in the list of disqualifying defects or conditions, the registrant should be sent to the joint examining and induction station for complete examination and determination of his acceptability.

CAN REVIEW AFFIDAVITS

"4. If in the opinion of the local board, after consultation with the Medical Advisor, a defect or condition claimed by a registrant is included in the list of disqualifying defects or conditions, arrangements should be made by the board for the Medical Advisor either to interview such registrant, or, if more convenient for the Medical Advisor, to review affidavits or certificates referred to in paragraph 6 of the Manual for Medical Advisors and filed with the board by the registrant, in order for the Medical Advisor to

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determine whether the registrant is actually suffering from the defect or condition.

"5. The Medical Advisor need not make an examination of a registrant unless he desires to do so but may base his opinion on affidavits or certificates referred to in paragraph No. 4 above, or on other information which may be in possession of the board. If in doubt as to the existence of a disqualifying obvious defect or manifest condition claimed by a registrant, the Medical Advisor is expected to so inform the board. In such case the board should arrange for the registrant to be sent to the joint examining and induction station for complete examination and determination of the registrant's acceptability.

"6. Should the Medical Advisor find it necessary or desirable to interview registrants claiming disqualifying defects or conditions, the board, if possible, should set aside space in its offices where such interviews can be held, unless the Medical Advisor desires to interview such registrants in his own office.

"7. If a registrant informs the local board that he previously had been rejected under Selective Service regulations for physical or mental defects or conditions, the board should request State Selective Service Headquarters for information and advice to assist it in properly classifying such registrant."

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since November 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing or temporary addresses in cases where physicians are taking postgraduate work.

COLUMBIANA COUNTY
William A. McGarey, Wellsville
William F. Stevenson, Salem

CUYAHOGA COUNTY
D. B. Cameron, Cleveland
Richard G. Ellis, Cleveland
Sidney Lobe, Cleveland
L. L. Lovshin, Cleveland

ERIE COUNTY
Donald B. Cuthbertson, Sandusky
Frank L. Maurer, Berlin Heights
W. P. Skirball, Castalia

LICKING COUNTY
Gerald A. Erhard, Newark
Warren Koontz, Newark
Robert S. Young, Johnstown

LUCAS COUNTY
William A. Blank, Toledo
James M. Diethelm, Toledo

MONTGOMERY COUNTY
Milton D. Feldman, Dayton

STARK COUNTY
Edmund Beshara, Canton
Thomas K. Ellis, Massillon

TUSCARAWAS COUNTY
Russell L. Oyer, Sugarcreek

Dr. James A. Doull, formerly a professor in Western Reserve University's School of Medicine and presently chief of the Office of International Health Relations, Public Health Service, has been detailed to the American Leprosy Foundation (Leonard Wood Memorial) as director of research. His appointment became effective November 1 with headquarters in Washington, D. C.

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Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

Two visiting physicians from Rochester, Minn., were on the afternoon and evening program of the Butler County Medical Society on Nov. 18. Dr. Frank Heck spoke on "Current Trends in Hematology" and "Splenectomy, Indications and Contraindictions." Dr. Malcolm Dockerty spoke on "Ovarian Tumors, Cystic and Solid" and on "Uterine Tumors, Benign and Malignant." More than 150 doctors attended the meeting and dinner.

CLERMONT

Dr. George E. Rockwell, Milford, assumed office as president of the Clermont County Medical Society on Nov. 17 following the annual election. Dr. A. A Gruber, Bethel, was named president-elect and Dr. J. M. Coleman, Loveland, was re-elected secretary. Dr. Rockwell was named delegate and Dr. Coleman, alternate.

CLINTON

Officers of the Clinton County Medical Society for the coming year are the following: Dr. E. Dalton Peelle president; Dr. Ralph H. Vance, vice-pres.; Dr. R. W. DeCrow re-elected secy.-treas.; Dr. E. K. Yantes, delegate; and Dr. R. R. Buchanan, alternate. All are of Wilmington.

HAMILTON

The Scientific Program of the Academy of Medicine of Cincinnati for February and March is as follows:

Feb. 1—Dr. Joseph Stokes, Jr. (the B. K. Rachford Lecture), professor of pediatrics, University of Pennsylvania School of Medicine, and physician-in-chief, Children's Hospital of Philadelphia, will speak on the subject, "Viral Hepatitis—Newer Developments in Knowledge of Etiology, Epidemiology and Clinical Aspects."

Feb. 15—Dr. O. Thompson, clinical professor of medicine, University of Illinois College of Medicine, will speak on "Uses and Misuses of the Sex Hormones."

March 1—Dr. William Dock, (the Roger Morris Lecture), director of medicine, Long Island College of Medicine, will speak on "Nephritis."

March 15—Dr. Alexander Brunschwig, professor of clinical surgery, Cornell University Medical College, will address the Academy on the subject, "Observations on Human Physiology Incident to Radical Surgery for Cancer."

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CHAMPAIGN

At the regular meeting of the Champaign County Medical Society, held Dec. 15, the action of the House of Delegates of the American Medical Association to assess each member of the A. M. A. $25 to provide a fund for educational purposes was discussed. The Society approved this action and the secretary was directed to notify the secretary and general manager of the A. M. A. and the executive secretary of the Ohio State Medical Association of the approval.

CLARK

The Clark County Medical Society announced the following officers for the year: Dr. W. D. Beasley, president; Dr. H. H. Ingling, pres.-elect; Dr. E. W. Schilke, secy.; Dr. N. S. Wright, treas.; Dr. Ray M. Turner and Dr. Ingling, delegates; and Dr. L. H. Mendelson and Dr. N. A. Brandeberry, alternates. All are of Springfield.

GREENE

Officers who will take office in the Greene County Medical Society on Jan. 6 are: Dr. Charles K. Schloss, Osborn, president; Dr. R. W. Barry, Xenia, pres.-elect; Dr. Robert D. Hendrickson, Xenia, secy.-treas.; Dr. C. G. McPherson, Xenia, delegate; and Dr. Paul D. Espey, Xenia, alternate.

MIAMI

Dr. Don F. Deeter, Troy, assumed office as president of the Miami County Medical Society on Dec. 3. Other officers are: Dr. W. W. Trostle, Piqua, pres.-elect; Dr. George A. Woodhouse, Pleasant Hill, re-elected secy.-treas. and named delegate; Dr. Burton M. Hoyle, alternate. The Society is starting a new series of Saturday broadcasts from Station WPTW at Piqua, entitled "Before the Doctor Comes."

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

ALLEN

Officers of the Allen County Medical Society for the coming year are the following: Dr. J. M. McBridge, president; Dr. H. L. Basinger, pres.-elect; Dr. John A. Glorioso, secy.; Dr. R. G. Hendershot, treas.; Dr. Fred P. Berlin, delegate; and Dr. M. D. Soash, alternate. Dr. Soash is from Bluffton; the others are from Lima.

AUGLAIZE

New officers of the Auglaize County Medical Society are: Dr. Elizabeth Kuffner, St. Marys, president; Dr. Robert Oyer, Wapakoneta, vice-pres.; Dr. W. F. Schmiesing, Minster, secy.-treas.; Dr. Roy C. Hunter, Wapakoneta, delegate; and Dr. Kuffner, alternate. Speaker for

the meeting was Dr. Nathan Kalb, Lima, who spoke on "The Psychiatric Treatment of Both the Psychotic and Non-Psychotic Patient."

HARDIN

New officers of the Hardin County Medical Society are: Dr. C. L. Johnson, Kenton, president; Dr. H. A. Kerns, Kenton, vice-pres.; Dr. J. A. Mooney, Kenton, secy.-treas.; Dr. F. M. Elliott, Ada, delegate; and Dr. W. D. Dewar, Kenton, alternate.

MERCER

The Mercer County Medical Society named the following officers for the coming year: Dr. R. G. Schmidt, Celina, president; Dr. C. P. Adkins, Coldwater, vice-pres.; Dr. A. J. Rawers, Celina, re-elected secy.-treas.; Dr. Eugene J. McLaughlin, Ft. Recovery, delegate; and Dr. Manning G. Harnick, Coldwater, alternate.

VAN WERT

Officers of the Van Wert County Medical Society for the year are: Dr. Roy E. Shell, president; Dr. W. C. Scheidt, vice-pres.; Dr. T. L. Edwards, secy.-treas.; Dr. Shell, delegate; and Dr. Edwards, alternate. All officers reside in Van Wert.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

DEFIANCE

Dr. James Cameron took office as the new president of the Defiance County Medical Society on Jan. 1. Other officers are: Dr. Harold J. Wenzinger, pres.-elect; Dr. F. M. Lenhart, re-elected secy.-treas.; Dr. D. J. Slosser, delegate; and Dr. P. B. Newcomb, alternate. All are of Defiance.

PUTNAM

Dr. Carll S. Mundy, Toledo, Fourth District Councilor, discussed current medical problems at the Dec. 7 meeting of the Putnam County Medical Society. Officers chosen for the coming year are: Dr. Milo B. Rice, Pandora, president; Dr. H. N. Trumbull, Columbus Grove, vice-pres.; and Dr. Donald B. Lucas, Columbus Grove, secy.

WOOD

The Wood County Medical Society held its regular dinner meeting at Don's Point Restaurant, Perrysburg, on Dec. 2. There was an unusually good attendance. Dr. Paul Orr presided.

The short business session was devoted to the election of officers. The following were elected: Dr. Paul Orr, Perrysburg, president; Dr. Frederick Price, Stoney Ridge, vice-pres.; Dr. James R. McAuley, Perrysburg, secy.-treas.

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Dr. Orr was named delegate and Dr. Frank V. Boyle, Bowling Green, alternate.

The Society was fortunate enough to have a visit from Dr. Carll S. Mundy, of Toledo, Councilor for the Fourth District and Chairman of the Committee on Rural Health of the Ohio State Medical Association. Dr. Mundy gave a brief report on the Interim Session of the A. M. A. at St. Louis and discussed the place of rural physicians in the American medical pattern.

The paper of the evening was given by Dr. Byron G. Shaffer, Toledo, on "Gynecology from the Standpoint of the General Practitioner." Dr. Shaffer stressed particularly Endometriosis and Leukoplakia as diseases seen in their early stages by the general practitioner and the critical place occupied by estrogens, X-ray and surgery in the treatment of these conditions, making accurate diagnosis an absolute necessity.

This was a directly informative paper based largely on Dr. Shaffer's personal experience and supplemented by a wide familiarity with the literature and was enthusiastically received by the members. Rising votes of thanks were tendered Dr. Mundy and Dr. Shaffer.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

GEAUGA

Officers of the Geauga County Medical Society who took office Oct. 27 are: Dr. H. E. Shafer, Middlefield, president; Dr. W. C. Cory, Chardon, pres.-elect; Dr. Isa Teed Cramton, Burton, re-elected secy.-treas.; Dr. Phillip P. Pease, Chardon, delegate; and Dr. Alton W. Behm, Chardon, alternate.

LAKE

Dr. Fred W. Dixon, Cleveland, Fifth District Councilor, reviewed recent actions of the Ohio State Medical Association at the Nov. 19 meeting of the Lake County Medical Society. Attorney Crawford Morris discussed the subject, "Legal Problems in Medical Practices."

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

PORTAGE

Portage County Medical Society officers for 1949 were announced as follows: Dr. Richard C. Neely, Ravenna, president; Dr. Elizabeth A. Leggett, Kent, vice-pres. Dr. Neely was designated the delegate with Dr. Leggett as alternate.

STARK

Stark County Medical Society officers who took office on Dec. 9 are: Dr. J. R. Rohrbaugh, Massillon, president; Dr. I. B. Hamilton, Canton, vice-pres.; Dr. R. E. Tschantz, Canton, re-elected

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secy.-treas.; Dr. L. E. Anderson, Greentown, Dr. R. K. Ramsayer, Canton, and Dr. C. C. Couch, Canton, delegates; and Dr. A. E. Boyles, Louisville, Dr. Harry Beck, Canton, and Dr. G. M. Wilcoxon, Alliance, alternates.

TRUMBULL

More than 100 physicians attended the annual Post Graduate Day of the Trumbull County Medical Society on Nov. 17.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

LAWRENCE

The following officers were elected at the November meeting of the Lawrence County Medical Society: Dr. John A. Dole, president; Dr. J. D. Swango, vice-president; Dr. Vallee W. Blagg, secy.-treas.; Dr. Wilson W. Lynd, censor; Dr. W. Ray Swango, delegate; and Dr. George G. Hunter, alternate.

MEIGS

Members of the Meigs County Medical Society elected the following officers for the coming year: Dr. Selim J. Blazewicz, Pomeroy, president; Dr. Charles J. Mullen, Pomeroy, vice-pres.; Dr. J. J. Davis, Middleport, secy.-treas.; Dr. R. E. Boice, Pomeroy, delegate; and Dr. John Philson, Racine, alternate.

SCIOTO

The annual dinner party of the Hempstead Academy of Medicine was held at the Portsmouth Country Club on Dec. 13. The party followed an afternoon business session at the Nurses' Home of General Hospital.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FAYETTE

Dr. M. H. Roszmann is president of the Fayette County Medical Society for 1949, with the following other officers: Dr. Joseph M. Herbert, vice-pres.; Dr. James E. Rose, secy.-treas.; Dr. J. H. Persinger, delegate; and Dr. Hugh Payton, alternate. All are of Washington C. H. except Dr. Payton who resides in Jeffersonville.

ROSS

Dr. Russell C. Bane was re-elected president of the Ross County Academy of Medicine for the coming year. Other officers are: Dr. Edwin H. Artman, pres.-elect; Dr. Walter E. Kramer, re-elected secy.-treas.; Dr. Ralph W. Holmes, delegate; and Dr. O. P. Tatman, alternate. All officers are of Chillicothe.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ASHLAND

Ashland County Medical Society officers for 1949 are: Dr. A. D. Robertson, president; Dr.

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G. D. Fridline, vice-pres.; Dr. R. J. Ferguson, re-elected secy.-treas.; Dr. Fridline, delegate; and Dr. W. C. Smith, alternate. All are of Ashland.

LORAIN

"Use and Abuse of Digitalis" was the subject of a talk by Dr. Harold Feil, Cleveland, at the Dec. 14 meeting of the Lorain County Medical Society.

RICHLAND

The Richland County Medical Society and the active staff of Mansfield General Hospital held a joint meeting at the hospital on Dec. 2. Guest speaker was Dr. B. K. Wiseman, Ohio State University College of Medicine, who spoke on "The Use of Antibiotic Drugs in Medicine."

WAYNE

Dr. William R. Schultz, is the new president of the Wayne County Medical Society for the coming year. Other officers are: Dr. E. E. Judd, vice-pres.; Dr. R. C. Paul, re-elected secy.-treas.; Dr. Lyman A. Adair, delegate; and Dr. H. G. Beeson, alternate. All officers are of Wooster.

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

ALLEN

On Nov. 9 the Woman's Auxiliary to the Allen County Academy of Medicine gave a benefit bridge party and bazaar in the Memorial Hospital Nurses' Home. The $430 cleared on this party has been placed in the student nurses' loan fund for student nurses at both Memorial and St. Rita's Hospitals.

ASHTABULA

Conneaut members of the Woman's Auxiliary to the Ashtabula County Medical Society were hostesses as the group held a dinner meeting at Cleveland Hotel, Conneaut. Seventeen members were present. Mrs. Walter Caulkins entertained with three whistling solos and Mrs. Richard Irving sang three numbers. They were accompanied by Mrs. Carlton Davis.

ERIE

The Woman's Auxiliary to the Erie County Medical Society had a luncheon meeting in November. The Auxiliary's project was discussed. Members plan to provide recreational facilities for student nurses at Providence Hospital. Guest speaker for the afternoon was Dr. Anthony G. Groscost whose subject was "Geriatrics." On Dec. 13 the auxiliary gave a Christmas tea at the home of Mrs. E. J. Meckstroth for nurses and personnel of Providence and Good Samaritan Hospitals.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society and the Medical Society members were guests Tuesday Nov. 9 at the home of Dr.

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and Mrs. S. C. Sneeringer at Shell Beach, Buckeye Lake. Lunch preceded the business session. Mrs. L. E. Stenger, gave a resumé of the talk given by Dr. Jonathan Forman, Editor of *The Journal*, when they were guests at the meeting of the Pickaway County Medical Auxiliary held in Circleville. After the meeting, motion pictures were shown of a recent trip to Alaska taken by Dr. and Mrs. W. D. Nusbaum and Dr. Stenger.

FRANKLIN

Dr. Sheridan W. Bell of the Methodist Church, Delaware, was guest speaker at the November meeting of the Woman's Auxiliary to the Columbus Academy of Medicine. His talk was correlated with the work for handicapped children which is the project to which the auxiliary members are devoting their time and effort.

HIGHLAND

Mrs. J. M. Byers of Greenfield entertained the members of the Highland County Auxiliary at a luncheon and afternoon of bridge at the Washington Court House Country Club on November 3. At the close of the luncheon Mrs. Walter Felson presented the gavel to the president-elect Mrs. W. M. Hoyt who conducted a short business session and gave a report of the district meeting in Cincinnati.

The Auxiliary had a luncheon and business meeting at the Greenroof in Hillsboro on Dec. 1. Plans were laid for a project for the coming year and an invitation to meet with the Clinton County Auxiliary on Dec. 7 was accepted.

JEFFERSON

Mrs. C. W. Kirkland of Bellaire was guest speaker at the meeting of the Woman's Auxiliary to the Jefferson County Medical Society. "Socialized Medicine" was Mrs. Kirkland's subject. Mrs. Carl Goehring, president, explained the scholarship fund for nurses The group made a contribution to the state scholarship fund. Members were asked to read "Death Is So Permanent" in the July *Reader's Digest.*

KNOX

Mrs. Charles Tramont was hostess to members of the Auxiliary to the Knox County Medical Society. Members of this auxiliary sold 500 pounds of pecans during November.

LICKING

The Woman's Auxiliary to the Licking County Medical Society held a one o'clock luncheon in Hull Place. Miss Freddie Terry of station WCLT was guest of honor. She is broadcasting by transcription a program of officers of the group to acquaint the public with avenue of education for public health.

LUCAS

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County helped man the exhibit at the Lucas County Fair. What started as a small venture turned into a real project. Exhibits from A. M. A. on heart, cancer, bone and muscles proved very interesting, drawing 3,686 people to the tent. Thirteen hundred pamphlets were distributed on a wide variety of subjects, heart, cancer, allergies, overweight, underweight, brucellosis and tuberculosis. Eight hundred forty-four chest X-rays were taken by the Mobile Unit of the Public Health Department.

Ninety members were present at the November luncheon meeting of the Auxiliary. The president, Mrs. W. W. Green, announced that 18 new members had been added. Mrs. E. B. Gillette, state president, spoke briefly concerning her experiences in attending national and state meetings. Mr. Grove Patterson, editor of the *Toledo Blade* was the guest speaker. His subject was "What I think Is the Road to International Peace."

Progress is being made by a city-wide committee working on a training school for practical nurses which will open early in January for Northwestern Ohio. Four special interest groups have been formed by members of this auxiliary: Child Development; Guidance in Leadership; Home Decoration; and Survey of Health Services.

MARION

The first meeting of the Woman's Auxiliary to the Marion County Medical Society was held October 17 beginning with a luncheon at Hotel Harding. Mrs. Mouser outlined the duties of the committee chairmen and it was voted to send a subscription to *Hygeia* to the twelve county schools in Marion County. Following the business meeting an auction of baked and home made articles brought by the members, netted $62.

MONTGOMERY

Mr. George Saville, Columbus, adressed the Woman's Auxiliary to the Montgomery County Medical Society when it met for luncheon for its regular October meeting. His subject was, "What Every Doctor's Wife Should Know About Public Relations?"

The November card party given by the Auxiliary and held in the Ballroom of the Hotel Biltmore, Dayton, was a financial and social sucecss.

OTTAWA

Members of the Woman's Auxiliary to the Ottawa County Medical Society devoted the November meeting to Christmas seal work as an aid in the annual county campaign. Following the meeting the doctors joined their wives for a social hour and refreshments. To help raise funds to furnish a room of the proposed addition to the Magruder Hospital, members of this

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 21, March 21. Vaginal Approach to Pelvic Surgery, one week, starting Feb. 14.

OBSTETRICS—Intensive Course, two weeks, starting March 7.

MEDICINE—Intensive Course, two weeks, starting April 4. Personal Course in Gastroscopy, two weeks, starting March 7.

PEDIATRICS—Intensive Course, four weeks, starting April 4.

DERMATOLOGY—Formal Course, two weeks, starting April 18. Clinical Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

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auxiliary sponsored a concert by the talented Mozart Club of Oak Harbor on Sunday, Nov. 21.

PICKAWAY

Members of the Woman's Auxiliary to the Pickaway County Medical Society and their guests met in the parish house, St. Philips' Episcopal Church in Circleville, Wednesday, October 27. Following luncheon, Mrs. Ned Griner presented Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal*, who chose "Election and Its Effect on Taxation" as his topic, stressing various charitable phases in which such taxation is utilized.

The Auxiliary entertained husbands and other members of Pickaway County Medical Society at dinner at Fox Farm near Chillicothe, on Dec. 9.

RICHLAND

Dr. Harry Wain, Richland county health commissioner, was the guest speaker of the Woman's Auxiliary to the Richland County Medical Society at the Mansfield Leland Hotel. Luncheon was served at tables decorated in the election theme. Thirty-five members attended.

The Auxiliary held a Christmas luncheon. Mrs. C. R. Damron, president, conducted the short business session. Mrs. J. L. Stevens conducted a discussion on recent articles appearing in leading newspapers on "Socialized Medicine."

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine held a social meeting on Dec. 2. Thirteen members met for dinner. Instead of the usual exchange of Christmas gifts, each member made a contribution to a fund which will be used to purchase equipment for the new hospital.

SANDUSKY

Five children from the hard-of-hearing class in Fremont appeared with their teacher before the Woman's Auxiliary to the Sandusky County Medical Association, guests and interested nurses. A demonstration of the deaf children's learning and progress in class was given.

SCIOTO

A birthday party given by the local doctors' wives at the Four Keys restaurant Thursday, October 14, marked the eighth birthday of the Woman's Auxiliary to the Hempstead Academy of Medicine. Covers were laid for thirty members and two guests, Mrs. E. Benjamin Gillette and Mrs. C. W. Kirkland. The official guests gave reports of the various organizations in the state and suggested projects that could be worked on in the local organization. A shower of useful gifts was given for the benefit of the County Home and the Children's Home. The members of this auxiliary voted at the November meeting to take orders for Oregon holly and the profits derived from the sale are to be used to purchase an oxygen mask for the auxiliary's lend-aid bureau. This meeting was held at the home of Mrs. Harry F. Rapp. Mrs. George E. Obrist presided, and an auction sale featured the entertainment. Eighteen members attended this meeting.

A luncheon at the home of Mrs. Clyde M. Fitch marked the December meeting of the Auxiliary. Following the luncheon, carols were sung. After the meeting was adjourned, a hobby show was held.





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STARK

The Woman's Auxiliary to the Stark County Medical Association netted $305 at the rummage sale held in November. This money was added to the Nurses' Scholarship Fund. One nurse at Alliance City Hospital, two at Mercy Hospital at Canton, and two at Aultman Hospital, Canton, are at present receiving scholarship money. On Dec. 14, the Auxiliary had a Christmas tea at the home of Mrs. L. H. Werley. The gifts brought by members were given to the Visiting Nurses Society and were distributed by them among children whom they visited.

SUMMIT

On October 23 the Summit County Medical Society and its Auxiliary had a very successful square dance. The project committee was in charge of the November meeting of this auxiliary. A panel discussion was presented at this meeting concerning the part the doctor's wife plays in the civic life of Akron at present.

UNION

The October luncheon meeting of the Woman's Auxiliary to the Union County Medical Society was held at the Dinner Bell. The meeting was presided over by Mrs. A. M. Johnston, president. Plans for the coming year were discussed and much enthusiasm was shown. The group was pleased to welcome into its membership Mrs. Walter R. Burt, Milford Center.

WASHINGTON

Physicians' wives who had formerly been nurses told of their experiences at a tea given Nov. 17 by the Woman's Auxiliary to the Washington County Medical Society. About one hundred junior and senior high school girls from Marietta, Newport, Lawrence, Lowell, Beverly and Metamora were guests of the Auxiliary.

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COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, April 19-22.

American Academy of General Practice Annual Scientific Assembly, Cincinnati, March 7-9.

American College of Physicians, Annual Session, New York City, March 28-April 1.

Annual Conference of County Society Presidents, Secretaries and Committeemen, Columbus, March 20.

Fourth Annual National Conference on Rural Health, Chicago, Feb. 4-5.




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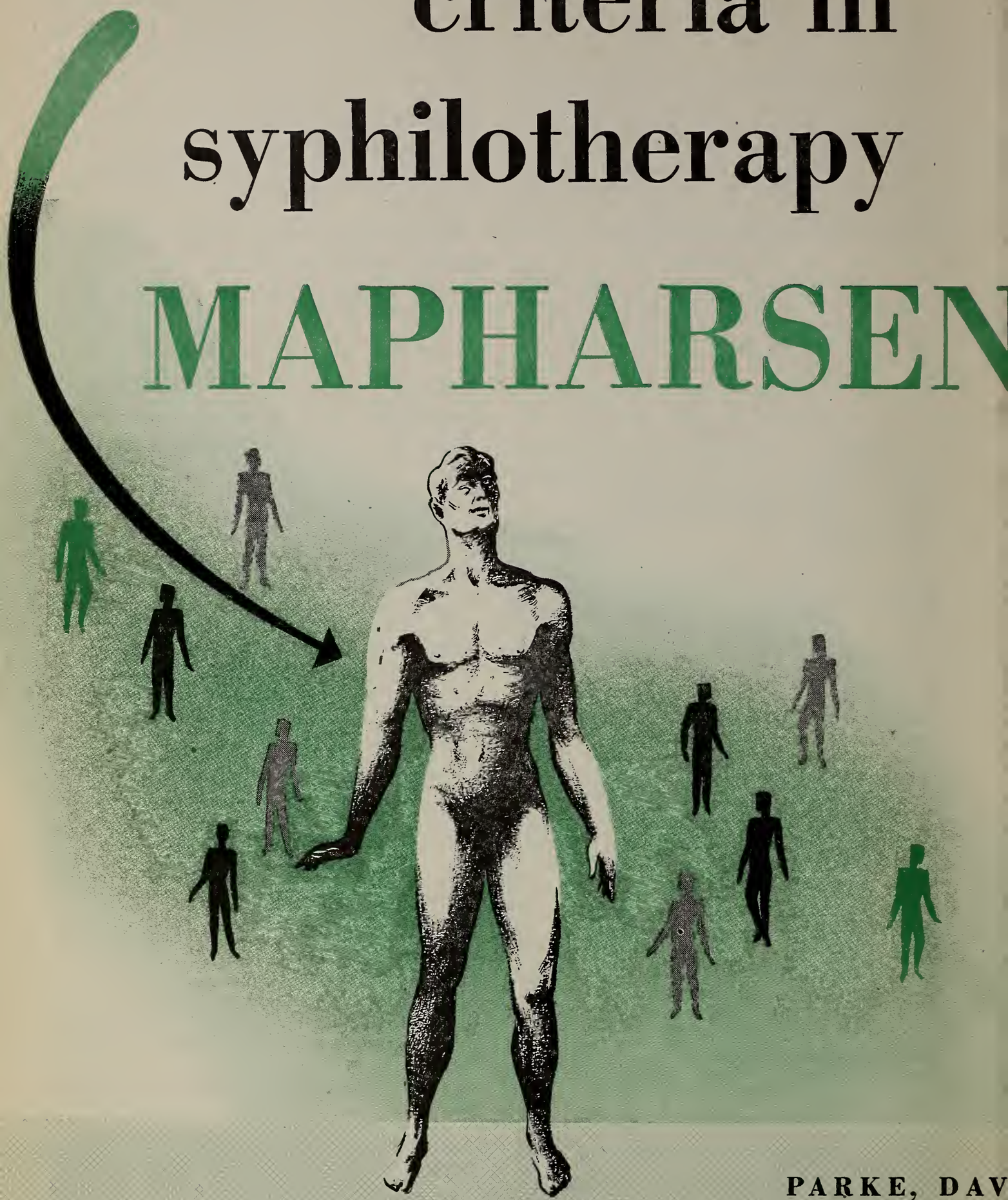
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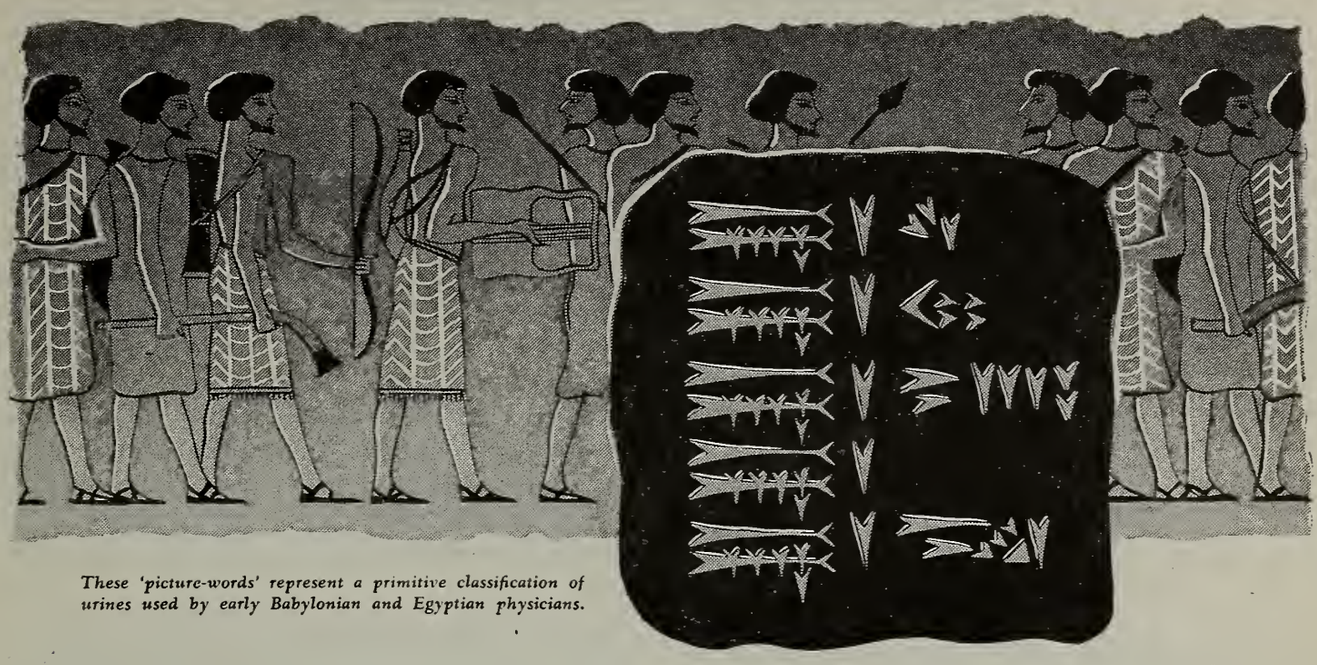
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The Physician's Bookshelf

By Jonathan Forman, M.D.

Anesthesia, Principles and Practice, by Alice M. Hunt, R. N., ($2.00. *G. P. Putnam's Sons, New York*) is a presentation for the nursing profession by a woman who has served the Surgical Department of Yale University with skill and devotion for 25 years. This volume serves its purpose well in that it is intended to give nurses the intelligent understanding of anesthesia that nurses should have.

The 1948 Year Book of General Medicine, ($4.50. *The Year Book Publishers, Inc., Chicago*) is one of the few compilations that no physician should be without as a current book of reference. I have been accumulating these on the shelves of my library for years. I find that they are an excellent source of information on any subject and its development in my time. I would recommend that every physician make it a point to collect the volumes in this series.

Pathology, edited by W. A. D. Anderson, ($15.00. *C. V. Mosby Company, St. Louis, Missouri*) brings together the specialized knowledge of some 30 pathologists who are well known for their investigations in the field covered by their contributions to this volume. It is just the type of text that a physician desiring to review any part of the subject, will want to use.

Gastric and Duodenal Ulcers, by Harold Avery, M.B., ($2.25. *Staples Press, Inc., New York City*) is an exceptionally well written monograph by the Senior Physician to Battersea General Hospital in London, England. The author presents in a concise, clever manner the clinical activity of the ulcer, the constitutional predisposition and the disturbing events in the patient's environment. These are carefully balanced and emphasis placed upon their correlation and the necessity of making the patient understand the relationship.

Handbook for Medical Secretary, by Miriam Bredow, ($2.75. *McGraw-Hill Book Company, New York City*) is the second edition of this pioneering volume. This excellent manual covers some 385 pages with answers to specific problems without attempting to duplicate material such as grammar, punctuation, use of telephone, or other material regularly found in textbooks for secretaries. This is a manual giving the medical side of secretarial work. Every physician will want to put a copy on his secretary's desk. It makes an excellent companion to and supplements and amplifies the points brought out in "Date With the Doctor and Some Helpful Hints for His Receptionist" which the Ohio State Medical Association put on her desk a few weeks ago.

Your Diet for Longer Life, by James A. Tobey, Dr. P.H., ($3.50. *Wilfred Funk, Inc., New York City*) is interesting as a practical authoritative, non-technical review of modern knowledge of food and nutrition. The author, after many years in public health and as an executive in the food industry is amply qualified to write this book. It is conservative in its viewpoint free of all fads, fancies, and similar follies.

Hope in Heart Disease, by Ruth V. Bennett, *(*$3.00. *Dorrance & Company, Philadelphia)* is the biography of the distinguished cardiologist, Louis Faugeres Bishop, M. D. Dr. Bishop was Manhattan's first "heart specialist." The title of this story indicates Dr. Bishop's great contribution to the subject. It took real courage to preach a gospel of hope in heart disease when Dr. Bishop began to do so. He always insisted that the despair which measuring and predicting the day of death engenders, was more likely to kill than the disease.

The Surgery of the Stomach and Duodenum, by T. H. Somervell, M.B., ($11.00. *Williams & Wilkins Co., Baltimore, Maryland)* is based on twenty-three years of gastric surgery in South India where ulcers are very frequently seen. It stresses the conviction that ligation of the gastric vessels and vagotomy are likely to prove very important in the treatment of this disease; and publicizes the transthoracic route as a means of access to the upper abdomen. In addition to being a personalized monograph it is also an excellent summary of the published work in gastric surgery.

Physician's Handbook, by John Warkentin, M.D., and Jack D. Lange, M.D., ($2.00. *University Medical Publishers, P. O. Box 761, Palo Alto, California*) is recommended as a pocket manual on the basis of its reception—five editions in seven years. It contains an amazing amount of material excellently presented for ready reference.

The Clinical Apprentice, A Guide for Students of Medicine, by John Naish, M.D., and John Apley, M.D., ($4.50. *Williams & Wilkins Co., Baltimore, Maryland*) is a wonderful little book which does just the job it is intended to do. It orients bewildered young men and women who, suddenly removed from the orderly domain of

Science, cross the No-Man's Land into the strange, empirical atmosphere of the wards, the casualty room, and the O.P.D. to find for themselves that the Practice of Medicine is not and never will be a Science, but rather an Art by which the findings of Science are applied in a practical way to the care of the sick. If you have any contact with medical students, reading this book will help you to help them. If you know a second or third year medical student, you can do him no greater service than to present him with this delightful little survey of what one should expect to encounter in learning this craft.

Congenital Heart Disease, by James W. Brown, M.D., ($5.50. *Staples Press, Inc., New York City*) presents a brief account of the condition with special emphasis on those lesions capable of clinical recognition when modern methods are employed. The volume is based upon the author's study of 350 cases.

Magic in a Bottle, by Milton Silverman, ($3.50. Second Edition. *Macmillan Company, New York City*) is the story of men who actually went out and worked to find aspirin, veronal, vitamin B, and penicillin. The author tells the story of Morphine, Quinine, Digitalis, Cocaine, Asperin, Barbitals, Vitamins, Hormones, "Sulphas," Penicillin, Drugs Against Epilepsy, and Atom-Smashers—all dedicated to his friend, Chauncey Leake.

Healthful Living, by Harold S. Diehl, M.D., ($3.50. *Whittlesey House, New York City*) is a popular text for those who want to get the most fun and joy out of their body for the longest possible time.

The Literature on Streptomycin, by Selman A. Waksman, ($3.00. *Rutgers University Press, New Brunswick, New Jersey*) summarizes some 1200 papers published in the first four years after the discovery of this drug. These are listed. This book is all the more unusual in that the discoverer himself has done it.

The Story of Blood, by John H. Glynn, M.D., ($3.00. *A. A. Wyn, Inc., New York City*) divides the subject into eleven interesting chapters. I was particularly impressed with his chapter on Blood and Allergy—it is one of the best popular explanatory summaries that has appeared. The other chapters are likewise excellent.

The Clinical Management of Varicose Veins, by David Woolfolk Barrow, M.D., ($5.00. *Paul H. Hoeber, Inc., New York City*) is a timely volume about a troublesome condition most frequently seen in the underprivileged and/or the aged. This work is presented clearly in a logical sequence and the emphasis is placed, according to Arthur W. Allen of Boston, "on the best methods, so far developed, to relieve the patient." It would seem to your reviewer that constitutional as well as mechanical causes should come in for reserch. Aside from notes on familial occurrences and obesity, nothing has been said yet about the state of nutrition affecting the blood vesicle walls.

Microbes Militant, A Challenge to Man, by Frederick Eberson, M.D., ($4.50. *The Ronald Press, New York City*) tells the story of modern preventive medicine and the control of infectious diseases; and is a revision of the author's previous volume, *The Microbe's Challenge.* It is still a challenging book. In addition to twelve delightful chapters giving exposition to his topic, the author has added a thirteenth dealing with faith and fate, describing man at war with Jungle Fever, Yellow Fever, and Malaria; and concluding with an essay on Environment versus Heredity and Constitution and ending with comments on the tolerance to germs that apparently come with age.

Textbook of Rheumatic Diseases, by W. S. C. Copeman, M.D., (*Williams & Wilkins Co., Baltimore, Maryland*) collects and correlates modern knowledge from the best sources, and is dedicated to H.R.H., The Duke of Gloucester, President of the Empire Rheumatism Council. The twenty-five contributors have presented the thinking of the Empire as Sir Wilson Jameson, speaking on behalf of the Minister of Health, characterizes one of the big tasks that the Government faces.

Danger! Curves Ahead, by Miriam Lincoln, M.D., ($2.50. *Macmillan Company, New York City*) is a clever title for a persuasive book on how to prevent and correct overweight by a clinician at the University of Washington School of Medicine, replete with encouraging before and after photographs, menus, and recipes. The book emphasizes that reducing is a medical problem and each case must be individualized. A man with healed tuberculosis, a nursing mother, a woman with a stroke, and an emotionally unstable person may all weigh 190 pounds and definitely need to reduce, but the method to be used must vary considerably and that is where the physician must take time to consider the man as a whole—not a soul in distress nor a brute with a big appetite. It is my opinion that we physicians ought to insist that our fat patients reduce and jump in and help them with their problem so that they do it safely.

Penicillin in General Practice, by J. L. Hamilton-Paterson, M.D., ($1.50. Second Edition. *Staples Press, Inc., New York City*) gives adequate details for the conditions with which the physician is likely to deal. It is done in a small, simple, volume that should appeal, and about a subject in which our experience is accellerating so fast and our ideas changing accordingly.

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*Snyder, M. L., Kiehn, C. L. and Christopherson, J. W.: Mil. Surgeon, *97*: 380, 1945. • Shipley, E. R. and Dodd, M. C.: Surg., Gynec. & Obst., *84*: 366, 1947 • Mays, J. L.: J. Med. Assoc. Georgia, *36*: 263, 1947. • Curtis, L.: Surg. Clin. N. America, 1466 (Dec.) 1947.

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JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Cancer Detection

GEORGE M. WILCOXON, M. D.

CANCER detection and cancer research presents to the scientific world a puzzle unlike any other in the medical field. To solve the mystery of malignancy and early cancer detection is one of the greatest problems confronting the world.

Interest in cancer has pyramided in the past few years. Any disease that takes an annual toll of 188,000 persons in the United States is of major concern to research workers, public health officials, private physicians, and, above all, the American people who suffer and die from it. There are now in the United States approximately 500,000 men, women, and children with cancer. During the years of World War II the deaths due to cancer for the same period of time were approximately twice the number of American war casualties.

OHIO CANCER

In the state of Ohio the cancer death rate of 144.3 per 100,000 population is higher than the average for the United States.[1] This is because Ohio has a large population group over 45 years of age. It is well known to all of you that cancer takes its greatest toll among persons over 45 years of age. The age group over 45 years represents 36.5 per cent of Ohio's population. This group has 95 per cent of the cancer deaths in Ohio. In our state one in every 6.7 persons over 45 years of age will die of cancer. Cancer causes death earlier in women than in men. There is a sharp rise in the death rate in cancer in women after the age of 35 years. This same rise does not occur in men until after the age of 45 years.

In Ohio there are approximately 8,000 cases of undiagnosed cancer today. Most of these 8,000 cancer cases are individuals who have not considered their symptoms of sufficient importance to merit a medical examination. Some of the few who have reported for physical examinations have been reassured by their physicians that their early symptoms were not important.

The Author

● **Dr. Wilcoxon, Alliance, Ohio, is a graduate of University of Chicago, The School of Medicine, 1934; diplomate, National Board of Medical Examiners; member, American Congress of Obstetrics and Gynecology; on staff, City Hospital, Alliance, and Mercy Hospital, Canton; and head of Smear Laboratory, Western Reserve University, University Hospitals, Cleveland.**

DELAY

Statistics of Miller and Henderson[2] show that when a woman has a cancer of the cervix that from the time of the first symptom until she receives her first examination there is a time lapse of five months. From the time of the first examination until she receives her first treatment the physician is responsible for a delay of 4.5 months.

While much has already been accomplished toward the control of cancer it is essential that physicians realize how much more can be done with the tools now at their command.[3] As the physician's experience with cancer increases he is apt to become pessimistic and too easily reconciled into accepting a high cancer mortality. This pessimism as well as the accompanying apathy are easily understood. Most cancers are in an advanced state when first seen and their

Presented before Section on Obstetrics and Gynecology at 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, March 30, 1948.

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care does not give rise to optimism. The common habit of looking forward to a new cancer "cure" as the only solution to the problem serves as fuel for this defeatist philosophy. To assume that things are in a bad way and nothing much can be done about it until a new cure is available is faulty reasoning and the key to much of the present difficulty. Study devoted to the problem of uterine cancer has convinced me that full realization and acceptance on the part of every practicing physician of the principle of early cancer detection represents the most important single item in the control of uterine cancers. Early detection of malignancies means early diagnosis of the unsuspected lesion.

EARLY DETECTION

Cancer detection as applied to early cancer of the uterus means a careful study of every woman patient; a regular pelvic examination every six months for each woman patient over forty years of age; also, a regularly scheduled examination for each patient who has the following:

1. Family history of carcinoma.
2. Carcinoma elsewhere in the body.
3. Chronic cervicitis.
4. Fibromyoma uteri.
5. History of suggestive carcinoma.

Under history of suggestive carcinoma one is trying to ferret out the very early malignancy. Advanced cancer of the uterus presents little difficulty in diagnosis. In the early case the principle and commonly the only symptom is spotting or bleeding. This may be slight at first and is characterized by being: (a) Intermenstrual or irregular; (b) progressive, of increasing frequency and amount; and (c) prone to follow trauma, such as postcoital spotting or contact bleeding.

Any woman presenting this symptom complex should be carefully examined, and a cervical or endometrial carcinoma should be suspected. About 15 per cent of patients with cancer of the cervix complain only of leukorrhea, a nonbloody watery, serous or purulent discharge. Some are symptom free, further emphasizing the need for periodic examination.

In examining for early cancer of the uterus, inspection and palpation are paramount. Every woman that goes to a physician's office should have her cervix looked at very carefully. This is not being done, as hundreds of women patients pass in and out of doctors' offices without having pelvic examinations.

DIAGNOSIS

Schiller's test of iodine solution to the cervix is of questionable value in the diagnosis of malignancy. Clark's test of probing the uterine canal is of suggestive value when it is positive. It is positive when bleeding occurs after probing the uterine canal. This means there is present a source of bleeding which must be investigated. Slight bleeding following bimanual examination of the uterus is suggestive. When an endometrial cancer is present the trauma of bimanual examination is sometimes sufficient to disrupt the continuity of the neoplasm and result in slight bleeding. In the majority of cases the diagnosis is not difficult provided suggestive symptoms are watched for and the diagnostic procedures are carried out.

Not all irregular spotting or bleeding in adult women is due to cancer, but in every instance cancer must be suspected until proved otherwise. Endocrine imbalance is commonly noted at both ends of the menstrual span. In many menopausal women this is the cause of both the spotting complained of by the patient and the endometrial hyperplasia found associated with it. The widespread practice of administering estrogenic substances to both premenopausal and postmenopausal women for almost any and all symptoms has injected another cause for bleeding into the picture. The spotting or bleeding sometimes resulting from such medication can usually be distinguished from that of neoplastic origin in that the bleeding ceases and does not recur after use of the drug has been stopped. The presence of a small cervical polyp may give rise to spotting. Removal of the polyp should correct the situation unless cancer is also present. The bleeding associated with some uterine fibroids is commonly in the form of prolonged or increased menstruation. Endometrial cancer and uterine fibroids may coexist.

FRESH CELL TEST

The best test for uterine cancer was brought forth by Papanicolaou[4] when he showed that cancer can be diagnosed by smears. In order to go along with the idea of diagnosing malignancies by smears, one should probably believe that a normal body cell becomes changed and develops into a cancer cell. One should also believe that a cancer growing in any of the body systems which has access to an exit has the ability to exfoliate its cells. This simply means that a malignancy sheds or exfoliates its cells the same as the skin does routinely. Thus a cancer in a bronchus exfoliates a cell into the bronchus and likewise a gastric cancer sheds a cell into the stomach. A urinary cancer gives off a cell which washes out with the urine and a uterine cancer throws off cells which can be collected from the cervix or the vagina.

Papanicolaou presented to the scientific world a very simple but effective procedure. He maintained that these exfoliated cells should be fixed immediately and not be allowed to dry.

He took these exfoliated or cast off cells and dropped them into alcohol and ether. This fixed the cells at once and they are called "fresh cells" in contrast to the dead dried cells that had been studied in smears for years. This simple step is what those interested in the early diagnosis of cancer have been waiting for. This test is accurate and under proper conditions it will tell whether a cancer is present or not when it is impossible to see or feel the cancer.

MICROSCOPIC DIAGNOSIS

There is growing evidence that cancer of the uterus, and especially cancer of the cervix, takes years to develop to the point where it shows symptoms. According to this viewpoint it takes years until a physician can visualize and palpate a cervical cancer in a living patient. Pund and Auerback[5] suggest that it may take as long as twelve years for a cervical carcinoma to develop. Taylor and Guyer[6] present a proven case with a seven-year history. Therefore, it takes a microscope to make a diagnosis of a very early cervical cancer.[7] The easiest and most efficient method today is to study the exfoliated cells in and around the cervix.

BREAST CANCER

In concluding, I would like to point out that almost every physician in this section can play a part in lowering the death rate in breast cancers. Early cancer detection of breast carcinomas is almost entirely physical examination. How many patients go through your office without periodic breast examinations? In some sections patients are being taught to examine their own breasts each month and if there is any variation in their breasts to report to their family physician immediately. It is suggested that every woman patient over forty years of age have their breasts examined every six months by their physician.

SUMMARY

The Ohio cancer death rate is higher than average for the United States because Ohio has a larger population group over 45 years of age. There are approximately 8,000 undiagnosed cancer cases in Ohio today.

Early detection of malignancies means early diagnosis of the unsuspected lesion. In uterine cancer a study of the exfoliated cells may tell whether a cancer is present or not when it is impossible to see or feel the cancer. Diagnosis of very early uterine cancers is a microscopic technic. Every woman patient over forty years of age should have a pelvic examination every six months with a study of the exfoliated cells in and around the cervix. The breast cancer mortality can be lowered considerably by routine periodic breast examinations.

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Acute Coronary Thrombosis

One word is appropriate about rehabilitation. I think patients spend too long a time in the treatment of acute coronary thrombosis. Some people lose their jobs permanently; they never get back to work because someone was free in telling them to take three to six months off. They are turned into social derelicts when six weeks might have been sufficient. It is very doubtful whether a patient would eventually live any longer having taken six months off than he would have lived if he had taken six weeks off. It certainly would have been better for his family, for his social status, if he had been back to work sooner and supported himself. I think the medical profession has been a bit too generous in handing out sentences like—"take six months off." It means no financial income unless a person has plenty of means. Time is precious and life is short anyway. To spend three months more for a doubtful gain and have the patient's family suffer is open to grave question. In general it seems to me that we should have our patients back to part-time or full-time duty sooner than is customarily carried out.

The main points of this discussion are that the treatment of some of the complications of acute coronary thrombosis may be very effective and occasionally life saving, that anticoagulant therapy is promising and that patients with acute coronary thrombosis may frequently be rehabilitated and returned to some useful occupation sooner than is often practiced.—Samuel A. Levine, M. D., Boston, Massachusetts, The Connecticut State Medical Journal, Volume XII, Number 11, November, 1948.

Bifrontal Lobotomy for Relief of Organic Pain

HARRY E. LeFEVER, M. D.

THROUGH the ages pain has been the most cogent factor in prompting the patient to seek relief from the physician. The intense suffering associated with inoperable carcinomas with metastases, syphilitic visceral crises, tic douloureux, and angina pectoris, needs only be mentioned to emphasize that there are many unsolved problems associated with the physiology of pain. In many instances surgical empiricism has preceded known anatomic and physiologic facts, in attempts to relieve the patient of some of these painful lesions. Certain clinical and experimental observations are of interest in an attempt to learn more of the pathways for the conduction of painful impulses and the methods employed for their surgical relief.

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SENSATION OF PAIN

The sensation of pain is part of an elaborate though primitive protective mechanism against noxious agents and as such is largely a thalmic sensation. Pain indeed has been defined by Sherrington as the "psychical adjunct of an imperative protective reflex." Because of the very nature of the sensation we feel quite firmly that one should not be too facile in depriving an individual of this protective mechanism. There are, however, many diseases in which the suffering is so intolerable that we may well say with Allbutt that "under such adversity long survival may be no blessing."

Usually when medical measures fail to bring relief, the surgeon has injected alcohol, severed nerves or spinal roots, resected part of the sympathetic system, performed chordotomy or tractomy. In some extreme instances the resection of the post central gyrus has been resorted to for the relief of intractable pain.

FIRST OPERATION

In 1945, Von Wagenen first performed a bifrontal lobotomy which completely relieved a painful phantom arm that had resisted other treatment. This case remains unpublished, but since that time this operation has been resorted to many times in order to relieve the pain of organic disease.

Bifrontal lobotomy is a surgical procedure, brilliantly conceived by Egas Moniz, and designed to relieve certain mental disorders. As patients who had been subjected to this surgical venture were carefully studied, it became apparent that they were no longer dominated by their hallucinations, and as a matter of fact, became indifferent to them, whereas, before the operation the patient might sit for hours listening to the voices, answering them at times, attempting to carry out their commands, and occasionally completely absorbed by the hallucinations.

Postoperatively the patient will usually admit that the hallucinations are still present, but he is no longer dominated by them. As one patient expressed it to Freeman, "The sensation has moved from the center of my attention to the periphery."

As further experience was gained, it was noted that the lobotomized patient was also quite indifferent to pain. The patient could be engaged in conversation and during which time a pin was used to stoutly prick the hand. He would make no effort to withdraw the extremity, would answer questions accurately, and at the end when asked whether the pin prick was painful, he would answer, "Certainly it was painful but I don't seem to mind it anymore."

PSYCHIC PAIN

Our first experience with the relief of so-called psychic pain by means of lobotomy was in 1942. T.E., a 47-year-old white female was examined in the Columbus State Hospital. For a period of eleven years she complained of a sense of pressure over the forehead and nose. As time went on the sensation increased. She had been repeatedly examined and X-rayed. She had been subjected to sinus drainage and alcohol injection into the supraorbital nerves without relief. Finally as she became depressed, aggitated, and suicidal, she was admitted to the State Hospital. She constantly repeated "Oh, the pain! Let me die!" The symptom of pain appeared excessive and out of proportion to the local conditions found at examination. She did not respond to the various conservative treatments, including shock therapy. On July 12, 1942, she was subjected to bifrontal lobotomy. Following the operation the improvement was rapid. She was able to return to her home at the end of three months, and never afterwards was noted to complain of the frontal pain. In this instance we felt we

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were dealing with a mental pain, or psychalgia, due to her psychosis.

ORGANIC PAIN

The first lobotomy carried out for the relief of organic pain was at the Veterans' Hospital in Chillicothe in February, 1945:

Case I. J. B., a 52-year-old white male had developed tabes in 1935. He had undergone prolonged chemotherapy and fever treatment. In 1937, the lightning pains had become so intense that a chordotomy was perfomed in Chicago. This was effective in reducing the pains for one year, after which time they returned with increased intensity. He was transferred to the Veterans' Hospital in Chillicothe in 1938, where narcotics were employed to control the pains about the abdomen and into both legs. On February 18, 1947, a bifrontal lobotomy was carried out. Following the operation he became more social, was interested in the affairs of the ward. The pain was still present but he appeared unmindful of it and he was withdrawn from the narcotics. Approximately once per month it is necessary to administer codeine for pain. However, the relief may be classified as satisfactory.

* * *

Case II. E. A., a 55-year-old white male was admitted to White Cross Hospital on June 30, 1947, with a carcinoma of the tongue, with large nodes of the neck on the right and left sides. He complained of sharp, stabbing pains in the left cheek and right side of the tongue. There was also pain in the isolated areas supplied by both 9th nerves and the second and third cervical dermatomes upon the right. Swallowing fluids or food was impossible, and he was given intravenous fluids to combat an extreme degree of dehydration. Later it was possible to pass a nasal tube and he was given high caloric, high vitamin fluids. In addition to the pain, he was apprehensive and anxious. It was the opinion of Dr. Parker that the reactions were normal for one with a painful, serious illness. In view of the extensive bilateral involvement, lobotomy was carried out on July 11, 1947. The postoperative response was extremely gratifying. He could eat and drink without complaining of pain in spite of the ulcer at the base of his tongue. He was relaxed and no longer obsessed with the idea that he harbored a fatal illness. He conversed freely with relatives and showed no evidence of confusion or disorientation. When asked whether he had pain, he repeatedly insisted that he did not. He would admit that pin prick was painful, but he appeared indifferent to it. On the morning of the fifth postoperative day his temperature rose to 104 degrees, pulse 120, respirations 52.60, and white count 10,000 with 80 per cent neutrophiles. He died on the afternoon of the fifth postoperative day. At autopsy it was found that the right middle and lower lobes were involved in extensive lobar pneumonia, with edema and congestion of the left lower lobe. The carcinoma involved the tongue, pharynx, with extensions into the regional lymph nodes.

* * *

Case III. F. B., a 33-year-old colored female, was admitted to University Hospital July 3, 1947, with extensive ulcerative epidermoid cancer of the tongue and with regional lymph nodes of the right neck. She complained of extreme pain in the tongue and pharynx. Talking, movement of the tongue and attempting to swallow was followed by bitter pain. She was dehydrated and emaciated. Mentally she was quite alert but apprehensive lest she not be given anodynes when the pain became severe. A lobotomy was carried out on July 11, 1947. She was confused for three days but insisted that she had no pain, and further, there was no evidence that she had the slightest fear of pain. This patient continued pain free until the thirty-fourth postoperative day when the ulcer extended into a great vessel of the neck and she died instantly.

* * *

We have recently had the opportunity to compare the relative merits of chordotomy and lobotomy in patients with similar lesions.

Case IV. M. M., a 27-year-old white female, was admitted to University Hospital February 9, 1948, complaining of severe pains across the lower abdomen and into the left leg. This patient was found to have a cancer of the cervix in January of 1946. On January 17, 1946, the uterus, cervix, tubes, and ovaries were removed and she received postoperative X-ray and radium treatment. In July she began to develop severe pains in the left leg and groin. These pains gradually became more and more intense and extended to the right side of the abdomen. In December of 1947 an epidural injection failed to provide relief. On March 2, 1948, bilateral chordotomy was carried out at the level of the second and third dorsal vertebrae. Following the operation there was a loss of pain and temperature sense below D-9 on the left and D-10 on the right. A temporary paresis of the left foot developed for two weeks. The pain was completely relieved, but a bladder incontinence was present. A Monroe tidal drainage was utilized for two weeks and there is still some dribbling of urine. Whereas the pain is relieved, the patient is apprehensive that it will return in spite of reassurance to the contrary. She is constantly asking what we shall do if the pain returns.

* * *

Case. V. A. S., a 33-year-old white female, was admitted to University Hospital March 7, 1948. She was discovered to have cancer of the cervix eighteen months ago. She was treated with X-ray and radium. In August of 1947 she began to complain of severe pain in the left lower abdomen and buttock. As time went on pain radiated into both lower extremities. Recent vaginal examination revealed stenosis of the vagina, and a mass in both broad ligaments. She was requiring dilaudid and morphine for relief of pain. On March 18, 1948, a bifrontal lobotomy was performed. She has had complete relief from pain and is the picture of equanimity. She harbors no fear that the pain will return and is most grateful.

CLINICAL IMPRESSIONS

We were impressed by the fact that in spite of the pain being relieved in the patient upon whom the chordotomy was performed, there is still the fear of pain, whereas in the case of lobotomy, both the pain and the fear of pain is eliminated. In these last four cases there was a structural basis for the pain. Following lobotomy there develops not only an indifference to the pain, but the patient becomes oblivious to

the fact that he harbors a serious illness. There seems to be an alteration in the reaction to pain upon the part of the patient, with still the ability to feel pain.

In a consideration of the surgical procedures designed to relieve pain there looms three stages. The first stage is the interruption of the peripheral nerve fibers (i. e., alcohol section or sympathectomy). In the second stage the central conduction pathways are cut in the cord, medulla, or mesencephalon. In the third stage the anterior thalamic radiation is severed, producing a decrement in the psychic reaction to a painful stimulation.

It is our opinion that bifrontal lobotomy is a most important means for the control of severe, intractable, intolerable pain due to lesions that may not be primarily attacked.

* * *

DISCUSSION*: With results empirically arrived at, one cannot quarrel, especially if they happen to be successful. Any procedure capable of relieving the agonizing pain, as for instance. of widespread metastatic malignancy, is a good one, whether rationally or empirically conceived. Nothing succeeds like success as several of Dr. LeFever's case reports demonstrate. Consequently one can only applaud his results and hope that bifrontal lobotomy will succeed in other's hands as well as in his.

The scientific mind, however, abhors the vacuum of empiricism and never satisfied with the result itself, hastens to discover or, to invent, if need be, physiologic or anatomic explanations. Out of this need to rationalize there is evolving today in connection with lobotomy a kind of "surgical phrenology" which in my opinion has about the same validity as the Lombrosian bumps on the head.

By a process of circular reasoning the proponents of lobotomy have constructed a streamlined version of the ancient mechanistic concepts of psychical function which threatens to negate the hard-won knowledge of psychiatry and psychology in favor of a simple idea wherein the psyche is thought of as an intricate machine composed of nuts, bolt, wires, conveying belts and the like. The circular reasoning goes like this: If one cuts the frontal lobes, the patient's emotional reactions are dulled—if one now examines such brains it is found that the fronto-thalamic fibers have been severed. Hence, the fronto-thalamic tract carries the emotional driving!

Illogical and superficial as this proposition may be, it is neat and pat, and has caught on, and has become the so-called scientific basis of lobotomy.

Actually, in my opinion, the clinical phenomena following lobotomy are entirely non-specific and depend only upon the fact that a certain mass of brain tissue has been destroyed. The easy accessibility of the frontal lobes and the absence of important sensory or motor structures within them make them an obvious target for the penetrating missiles we call lobotomies. For penetrating wounds of the brain, we neurosurgeons, even though we make them slowly, make them deliberately and aseptically.

Exactly the same apathies, the same indifferences, the same emotional dullings, the same uncomplaining attitudes toward pain, the same inabilities to project into the future and the same ignoring of stimuli were noted a hundred times over during the war in men struck elsewhere in the brain than in the frontal lobes by enemy missiles. Unfortunately serious motor and sensory defects were often present.

Yet, to my way of thinking the emotional responses of these men were in no way different from those described after frontal lobotomy. In short, any destruction or disease of the brain will impair the total adaptive and integrative functions of the individual so that he will not respond with the same intensity to stimulations arising from without or from within him.

Not only are the surgical injuries to the brain of a non-specific kind but lobotomy can be applied indifferently to the patient regardless of whether the pain is a delusion or psychalgia, or whether it is due to organic causes. The net result is, as. Dr. LeFever shows, quite the same. This is cogent evidence, to my mind, that interruptions of specific tracts have nothing to do with the result. As a matter of fact it has long been known that when psychotics fell out of asylum windows and sustained diffuse cerebral injuries, there was subsequent improvement in their behavior, and I dare say, also in their psychalgias.

With all this in mind, I believe the operation is justified on patients with incurable carcinoma. Surely nothing is lost, but so far as the pains of non-organic origin are concerned, I feel that less mutilating measures are desirable.

When dealing with patients suffering from so-called psychalgias, it would seem that we had better treat the disturbed psychologic state by psychologic techniques rather than surgically create people who feel well only because they are incapable of feeling badly!

If physical means must be resorted to, less hazardous and less permanently damaging methods might be employed, such as electro-shock therapy, which has the virtue at least of being safer, if just as empirical.

By safer, I mean that there is less hazard of producing surgical death, hemiplegia or late epilepsy. One must remember that about 25 per cent of penetrating and destructive cerebral wounds result in epilepsy.—L. M. WEINBERGER, M. D., Akron, Ohio.

* This discussion of Dr. LeFever's paper was presented by Dr. Laurence M. Weinberger of Akron, Ohio.

Sensitization to Penicillin: The Types of Reactions; Therapy and Prevention

MILTON D. FELDMAN, M.D.

PENICILLIN, a powerful antibiotic agent, may be a life-saving medication. On the other hand, indiscriminate use may lead a physician into complications far beyond any he had ever expected. This is seen too frequently when penicillin is used for the treatment of minor disturbances where other chemotherapeutic agents would serve as well.

The adverse symptoms produced by penicillin may be grouped into five categories:

1. It may act as a direct toxin or primary irritant.
2. It may act as an antigen and stimulate antibody formation.
3. It may induce a Herxheimer reaction.
4. It may induce "therapeutic paradox."
5. It may induce organism resistance.

One must distinguish between the allergic reactions produced by penicillin and those reactions which are caused by its toxic or irritant properties. Most individuals will develop symptoms of central nervous system irritation when a concentrated solution of penicillin is injected intrathecally. It has been suggested also that concentrated solutions of penicillin used locally may interfere with wound healing. We have not found this to be true experimentally with ointment containing as much as 20,000 units per gram. In contrast, only a few develop urticaria when penicillin is administered parenterally. The latter is a specific, acquired and altered reactivity and is a manifestation of allergy or hypersensitivity. The allergic reactions to penicillin, produced because of its antigenic properties, can be divided into several different types:

1. Allergic dermatitis of the contact type.
2. Drug and serum-like reactions.
3. Erythemato-vesicular group of reactions.
4. Tuberculin type of reaction.
5. Arthus-like reactions.

It has been shown that commercial and crystalline penicillin possesses definite antigenic properties. In regard to the allergic reactions, the earlier literature stressed the relative innocuousness of penicillin. As its use became more extensive, various types of allergic responses have been described until the present time when such descriptions are extensive. With the advent of the many different types of penicillin preparations and the numerous methods in which these can be used, there is no wonder about ample opportunity for sensitization. Allergic reactions may be due to the penicillin itself or they may arise from impurities contained in individual batches of the extract. Sensitization has been demonstrated by patch and scratch testing, intradermal testing, passive transfer tests, precipitin tests and Schultz-Dale tests Penicillin may combine with human protein or bacterial protein to act as a hapten.[1] In addition, cross-sensitization can occur when an individual has become allergic to other substances containing a common, similar or related antigenic factor,[2] such as trichophytin.

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ALLERGIC DERMATITIS OF THE CONTACT TYPE

This manifestation of allergy occurs when the epidermis and mucous membranes have become sensitized. The dermatitis becomes manifest after a period of previous contact and once sensitization has been established, symptoms may result after contact with minute amounts of the agent. Both the skin and mucous membranes may participate in this reaction. Examples of the latter are seen in reactions about the lips, mouth, and gastro-intestinal tract following ingestion of penicillin tablets, penicillin sprays, troches, and lozenges. Systemic reactions from absorption of penicillin from these compounds may also occur.

Circulating antibodies have not been proven to exist in allergic contact dermatitis.[3] Regarding the mechanism of sensitization, the reaction is specific, and antibodies if present, must be sessile and exist in or are attached to the epidermal cells themselves. Contact with the sensitizing preparation results in an antigen-antibody reaction at the epidermal level. The response is one of edema and vesiculation within the epidermis, secondary superficial dermal vascular dilatation and transudation of the cellular and fluid elements of

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the blood to produce the clinical picture of eczematous contact dermatitis.

DRUG AND SERUM-LIKE REACTIONS

Tuft[3] states that there are marked similarities between the allergic reactions to drugs and to serum. They are similar in types and the symptoms they produce. Any difference which exists depends apparently upon the colloid or protein property of serum allergens as distinguished from the crystalloid character of the drug allergens. The underlying mechanism seems to be the same for both conditions.

The reactions with which we are concerned may be of two types:

1. The introduction of penicillin into a non-allergic or normal individual who has never been sensitized by this allergen, may be followed after an incubation period of days, usually 5 to 14, of the symptom complex known as delayed serum sickness type reaction. This is characterized by fever, skin eruptions, adenopathy, and arthritis.

2. In some individuals who have previously received penicillin, an allergic response analogous to acquired serum allergy will result. These symptoms resemble the ordinary delayed type of serum sickness reaction, but are usually immediate and more severe. In fact, a picture resembling anaphylactic shock of animals may result. It apparently is not a true anaphylaxis, but this type of reaction represents the closest prototype in the human being and is probably similar in its mechanism.

In addition to serum sickness-like symptoms, various skin eruptions are seen. Most prominent and common are urticaria and angioedema. There may also occur morbilliform, scarlatiniform, and blotchy erythemas; papular, papulovesicular, bullous and exfoliative dermatitides; erythema multiforme, erythema nodosum and petechiae and purpuric eruptions.

The exact mechanism of these reactions is not known. Circulating antibodies have frequently been demonstrated by passive transfer tests. Most generally accepted is the theory that the reaction resulting from the union of the antigen and antibody result in the symptoms. Some recent studies, however, indicate that the symptoms are an expression of the immune reaction involved in the production of the antibody instead. Some workers postulate that the union of the antigen and antibody mediate the liberation of H or histamine like substance which is responsible for the symptoms produced.

Nevertheless, the shock tissues, for the most part, are the cells located in the blood vessels of the cutis. Damage to these are responsible for the increased vascular dilatation and permeability. The transudation of cellular and plasma elements of the blood into the skin, mucous membranes and synovia produce the various pictures seen clinically. The deeper layers of epidermis may also be sensitized.

ERYTHEMATO-VESICULAR GROUP OF REACTIONS

This group of reactions include the eruptions appearing very shortly after parenteral or oral administration of penicillin. The dermatitis involves primarily the skin of the feet, hands and crural area where there may or may not have been some previous vesicular eruption suggestive of an epidermomycosis.

In ringworm infections, an allergic manifestation referred to as an id sometimes occurs. The ringworm infection may be localized to one area of the body, however, other lesions which do not contain the fungus occur in different areas of the skin, particularly on the fingers, hands, toes and feet. This secondary type of reaction is known as an id and is the result of sensitization of the skin of the involved areas to the fungus trichophytin produced by the hematogenous distribution of the toxin.

Fungi produce a penicillin-like substance.[2] Previous fungus infections in some area of the body elaborate circulating penicillin-like products. These sensitize the skin of the hands, feet, crural area, and even the skin of the trunk. This sensitization may not become clinically apparent until at a later date when exposure to the antigen again occurs. Intramuscular or oral penicillin may act as the form of exposure.

The mechanism of sensitization is probably analogous to that producing the id type reactions and corresponds fairly closely to the tuberculin type of bacterial allergy. Circulating antibodies are not found and it is assumed they are fixed to the cells where the site of reaction takes place. Testing intradermally produces a tuberculin type of response, the sensitization originates from some primary focus of infection and there is a generalized dermal hypersensitivity. The epidermis is the primary level involved although the cutis is also sensitized.

TUBERCULIN TYPE OF RESPONSE

Rostenberg and Welch[4] and Epstein and Pinkus[5] have reported cases of hypersensitivity of the tuberculin type. In one case, the patient developed a dermatitis of the fingers from exposure to penicillin and positive patch tests only at the site of the previous dermatitis.

This was presented as a penicillin dermatitis based on tuberculin type sensitivity. In the other case, positive patch tests were elicited only at the sites of previous intradermal injections with penicillin. The patient had come into contact with various molds and fungi for a long period of time and it was believed that a possible subclinical infection with penicillium or an immunologically related species may have been responsible for his hypersensitivity. These probably represent the id type of reaction previously

discussed. Patients with contact dermatitis to penicillin have been shown by Goldman, Friend and Mason to exhibit tuberculin type responses also.[6]

ARTHUS-LIKE REACTIONS

This is a more or less severe reaction at the site of reinjection of an allergen. It is marked by inflammation, edema, induration and occasionally one sees necrosis and sloughing. Such cases have been reported following the use of subcutaneous injections of penicillin in oil and beeswax. A similar reaction has been reported with the local use of penicillin on an operative wound in a patient who had shortly before received injections of penicillin in oil and beeswax and who was concomitantly being treated with penicillin injections every three hours.[7]

It is believed that the penicillin which is injected remains in situ long enough to combine with body proteins, thus forming an antigen in which the penicillin molecule acts as a hapten. It is a type of local tissue hypersensitiveness in which the sensitized cells react with the injected allergen and is probably due to the contact of the antigen and antibody with the local tissues. As a result, there is arteriolar spasm; the endothelial damage due to the blocking of the vessels by leukocytic and red blood cell thrombi in turn leads to the hemorrhage, necrosis, and slough.

In the analysis of all types of reactions to penicillin the Department of Dermatology serves as a reporting center for these reactions. Where possible, all cases are reported and tested and detailed accounts of these reactions are recorded. Unfortunately, many of the patients (especially the urticaria-angioedema type), characteristic of penicillin reactions from the standpoint of both clinical manifestations and history, failed to give positive tests to prove their allergic nature. We have seen reactions following the use of oral tablets, penicillin in oil and beeswax injections, topical therapy with ointments and solutions, and parenteral injections with aqueous solutions.

1. The most common reactions have been those of urticaria and angioneurotic edema. Eight cases of acute urticaria and urticaria in combination with angioneurotic edema have followed oral ingestion and aqueous and oil in beeswax injections of penicillin.

2. Next in frequency of reactions seen have been the maculo-papular and papulo-vesicular responses. In this group are included the id type of reactions. There are records of 11 patients with these types of responses. Seven had a generalized eruption; in four this was especially marked about the hands, feet, and/or groin. In addition, one of these patients had an extensive bullous dermatitis and later exfoliated generally. Five of these 11 patients had an id type dermatitis involving only the hands, feet and crural areas. Five patients gave a history of previous fungus infection or had active foci of infection when seen.

3. There has been two cases of stomatitis and cheilitis from the use of oral tablets. In a previous series reported from this Reaction Center, two patients developed contact glossitis from penicillin. One patient developed glossitis, gastro-enteritis, and proctitis in addition. He died of a coronary artery thrombosis while in the hospital. An autopsy was performed and presumptive evidence of intestinal mucosal hypersensitivity was found. The other patient, in addition to his cheilitis and stomatitis, developed a generalized papulo-vesicular eruption.

4. One patient developed a focal penicillin stomatitis. Six months previously he had been given penicillin parenterally for three days and reacted with edema of the tongue with exfoliation and fissuring. Two hours after he received an injection of penicillin in oil and beeswax, he reacted with dryness of the mouth, hoarseness, sore throat and exfoliation of the tongue.

5. We have records of three cases of serum sickness-like reactions, all of which had urticaria and angioedema.

6. One young woman who received very large doses of penicillin for subacute bacterial endocarditis developed fever, chills, urticaria, and a papular dermatitis. Since it was necessary to continue the medication, her reaction became more severe and was characterized by petechiae, convulsions, coma, and negative blood cultures. The reaction subsided when penicillin was discontinued.

7. One patient, a 12-year-old child who had previously received penicillin, developed a serum sickness-like reaction, generalized erythroderma which progressed on to a papulo-vesicular, bullous and severe exfoliative dermatitis, generalized lymphadenitis, spiking fever, and a white blood count of 108,000 with a very high eosinophilia. This leukamoid reaction is uncommon and will be reported in detail later.

8. There have been two cases of necrosis of the buttock following the injections of penicillin in oil and beeswax.

9. Several types of purpuric reactions have been seen. One patient had an erythroderma and purpuric vesicles, another purpuric bullae in association with urticaria, a third patient developed a bathing trunk distribution of a purpuric crural id reaction, and the fourth patient reacted with purpuric lesions on the lower extremities, hips, and anterior trunk.

Kile[8] recently reported a patient who reacted to procaine penicillin. Patch tests to both procaine and penicillin were positive, however, the patient reacted with an eczematous dermatitis to procaine. Goldman's[9] patient was sensitive

only to the procaine and not the penicillin of procaine penicillin G.

No organism dependency has been described for penicillin as in the case of streptomycin.[10]

Reactions to streptomycin, gliotoxin, and even tyrothricin have also been studied but will not form part of this report.

PREVENTION OF PENICILLIN REACTIONS

In regard to the prevention of reactions, the following are important points:

1. Do not use penicillin, either parenterally or topically, indiscriminately:
   a. It is a highly sensitizing agent.
   b. Reserve its use for indicated conditions where the organism is sensitive to its action.
2. Inquire if the patient has had previous penicillin therapy and if a reaction did or did not occur:
   a. A reaction noted during or after exposure to penicillin may not recur on re-exposure.
   b. Previous exposure may have induced a state of hypersensitivity.
   c. Spontaneous hypo or desensitization may occur (frequency?).
3. Inquire about previous fungus infections and id type reactions:
   a. Dermatomycosis predisposes to sensitization.
   b. Treat existent fungus infections.
4. If hypersensitivity is suspected, skin test the patient:
   a. Patch test for epidermal sensitivity.
   b. Intracutaneous tests for dermal sensitivity are often unreliable indicators of the patient's ability to tolerate therapy.
5. Do not use topical penicillin for more than five or seven days, or discontinue its use at the first sign of a reaction:
   a. Prolonged use increases the rate of epidermal sensitization.
6. Protect the skin from contact with penicillin:
   a. Applies particularly to those handling penicillin. Penicillin dermatitis is an occupational disease of physicians and nurses.
   b. Technique in handling syringes—keep closed technique.
   c. Wash hands well after exposure.
7. Concomitant administration of antihistaminics will allay a reaction or make the patient more comfortable:
   a. This applies particularly to urticarial types of reactions.
8. Discontinue penicillin therapy in major types of reactions, especially where there are erythemato-vesicular and immediate serum disease-like reactions:
   a Severe exfoliative dermatitis may otherwise result or serum disease-like symptoms may occur.
   b. Give therapeutic doses of an antihistamine.
9. When penicillin in oil and beeswax is used, inject it intramuscularly:
   a. Subcutaneous injection predisposes to local tissue sensitization.
   b. Prefer procaine penicillin G mixtures. Watch for procaine intoxication in children, being careful about the dosage. Patch test to avoid procaine sensitivity in suspected procaine sensitive individuals.
10. When a patient is hypersensitive, desensitization can be attempted with gradually increasing doses of penicillin:
   a. Desensitization by injections.
   b. Desensitization with oral tablets—less suitable.

TREATMENT OF REACTIONS

The following general principles should be considered in the treatment of reactions:

1. Remember that spontaneous desensitization may occur.
2. Discontinue treatment with penicillin unless there is a critical need for the medication:
   a. Especially for contact dermatitis, generalized erythemato-vesicular eruptions and immediate serum sickness-like reactions.
3. Give therapeutic doses of an antihistaminic.
4. Intravenous benadryl can be used in an attempt to allay severe reactions without interrupting therapy:
   a. This will often permit continuation of penicillin.
5. Try other symptomatic dermatological and systemic therapy:
   a. Intravenous calcium, nicotinic acid and procaine (caution!).
6. When the symptoms subside, give an intramuscular test dose of 1000 units of another brand of penicillin:
   a. Have epinephrine or intravenous benadryl at hand.
   b. Continue with oral antihistaminics; change antihistaminics if no response occurs from one type in four to five days.
7. In the event of no reaction to 1000 units in four hours, give 10,000 units and increase the dosage by 10,000 to 20,000 units every four hours if the patient remains asymptomatic:
   a. Penicillin can often be resumed in full therapeutic dosage.
8. If reactions recur, increase the antihistamine to the effective level:
   a. In some patients, the antihistaminic can be discontinued.
9. During the trial administration do not use penicillin in oil and beeswax or procaine penicillin because of slow absorption of these types:
   a. In case a reaction occurs, rapid excretion of penicillin is desired.

10. In spite of previous and severe urticarial-angioedema reactions, penicillin may sometimes be given again without reaction.

CONCLUSIONS

The types of allergic reactions and the mechanisms of sensitization to penicillin are discussed. Important points in the prevention and treatment of such reactions are reviewed. The allergic responses to penicillin may be severe and temporarily disabling. However, spontaneous desensitization may occur. A plea should be made against indiscriminate use of penicillin. It is a highly sensitizing agent and when used in minor disturbances, not only may these reactions result, but the patient may also become sensitized to future therapy with this valuable antibiotic agent.

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Headache from Pathology in the Neck

One of the most common of all headaches is that caused by hypertonicity of the neck muscles. Any pain in the head, neck, shoulder, chest or precordium, aggravated by movement of the cervical spine by hyperextension, coughing, sneezing or straining, is apt to be due to arthritis of the cervical spine. Thus, about 40 per cent of early morning occipital headaches are thought to be caused by spinal arthritis. In middle and advanced age groups, headaches due to this condition rank in frequency with ocular and migraine headaches. The diagnosis is often overlooked. Such headaches are particularly apt to occur in bookkeepers, typists, proofreaders, and dressmakers.

The scalenus anticus syndrome and cervical ribs are uncommon causes of headache. Atlanto-occipital lesions may cause headache.—Joseph B. Stevens, M. D., Greensboro; N. C. Medical Journal, Vol. 9, No. 12, December, 1948.

Care of the Toxic Newborn

Toxemia of the mother is one of the most difficult problems faced by the obstetrician; toxemia as a complication in the newborn is frequently overlooked and too often leads to a mortality which might have been prevented. There is no doubt that care of the toxic newborn must begin prior to the time of delivery. Detailed knowledge of the proper analgesics to use, type of delivery to be undertaken, length of labor to be permitted to the toxic mother, nutrition of the mother, oxygen intake of the mother, type of anesthetic to be employed, all have important effects not only on the mother but also on the baby. This is important to such an extent that if proper knowledge is employed in all of these particular factors, more babies can be saved. The use of the proper analgesic, for instance, will in most cases improve the prognosis for the baby long before it is born. These factors are most important when prematurity complicates the situation.

In order to understand how to handle a toxic baby, it is necessary to know what complications, resulting from toxemia, may occur in the baby. These may be divided into two groups: (1) those complications occurring at the time of delivery; (2) those complications (which may be termed delayed complications) which are often apparent during the first ninety-six hours after birth.

In spite of all precautions and treatment, toxic babies are notorious for sudden change in their course.

In order to prevent as many complications as is possible, it is necessary to understand that analgesia should be as light as feasible, that delivery be as atraumatic as possible, that length of labor itself be held to a minimum, that the anesthetic employed be one that is not injurious to the baby. The mother should have had proper nutrition, and a proper fluid and mineral balance. Oxygen should be given to the mother, preferably just before labor, during labor, and at the moment of birth. Once these measures have been undertaken, the necessity of a trained resuscitator at the delivery cannot be overemphasized. The very recognition that toxemia exists is itself sufficient evidence that trouble is apt to ensue, and the necessity for immediate proper resuscitation of the baby is a prime point. After-care of the baby, once he has been resuscitated and removed to the nursery, consists primarily of heat, fluids, and a minimum of handling. Following the above simple routines may lower the mortality among toxic babies to such an extent that toxemia will no longer hold the dread place it occupies at present.—J. D. Russ, M. D., New Orleans; New Orleans Med. & Surg. Jrnl., Vol. 101, No. 6, December, 1948.

Early Ambulation In Postoperative Patients

HAROLD P. SHAPIRO, M.D.

THE practice of getting patients up early following surgery is not entirely new. It has been a routine method of treatment with a few surgeons at various times for more than fifty years. However, in the past four or five years, the attitude toward early ambulation has been rapidly gaining in popularity and I feel with good reason.

Having the patient sit up in bed, dangling his legs over the edge of the bed, or sitting in a chair, may be termed early rising, but is not ambulation. As used in this paper the term ambulation means actual walking, and the term early as used is this paper means within the first twenty-four hours. Frequently the patient is gotten out of bed to walk the evening of the day of surgery. Patients are not forced out of bed routinely. If they are sick, running a high fever, or having severe pain, they are allowed to remain in bed. However, most cases that come to surgery are elective. The patient is well enough to be up and walking about before operation and it does not necessarily follow that the operative procedure in itself will make him so sick he has to be confined to bed for a couple of weeks.

BED REST

The conventional method of treating patients postoperatively by prolonged bed rest has been accepted so universally for so long a time that the idea of a sudden departure from this method is not readily acceptable, and the question arises, "Why should we change to early ambulation?"

We have been taught to believe that bed rest promotes healing. The aphorism, "Rest in bed is the best prescription that was ever written," is still widely accepted. There is the assumption that energy saved from physical activity will be used to hasten repair of a wound; that by keeping a patient at rest in bed there will be fewer disrupted wounds and fewer incisional hernias; that less strain will be placed on the body economy; and in general, the chances for postoperative complications will be decreased.

Actually, complete bed rest is not a physiological mode of life. Bodily functions are atuned to activity, not to rest. It has been adequately shown that heart action, circulation, tissue metabolism, and, therefore, wound healing is better with reasonable activity than with prolonged rest.

It has never been possible to keep small children lying flat in bed following operation, unless the child is really sick. As soon as the effects of the anesthetic have worn off, he is standing up and walking around his crib, and surprisingly enough, there does not follow a disproportionately large number of disrupted wounds or incisional hernias. Also because of a fear of postoperative pneumonias, elderly patients have been gotten up earlier than usual following operation and the percentages of postoperative hernias have not been increased thereby. If this is true of the very young and the very old, it must also be true of the age group in between.

The Author

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WOUND HEALING

As a matter of fact, it has been shown statistically by several men that wound disruption and postoperative hernias are decreased by practicing early ambulation in postoperative cases.

Wounds disrupt, and incisional hernias result, when wound healing is not adequate to withstand intra-abdominal pressure. Wound healing is delayed by bed rest because circulation is poor and tissue metabolism is impaired. We know that with a patient confined to bed, it is extremely difficult to keep him in calcium balance and that more than twice the amount of protein in the diet is necessary to keep him in normal nitrogen balance. The best way to provide patients with protein is by giving them food by mouth, but the patient at complete bed rest will not take an adequate diet nearly as well as one who is ambulated early.

Intra-abdominal pressure is not increased by getting the patient up early. The patient can be helped out of bed with no more strain upon his incision than he produces by rolling over in bed. Walking does not test his wound as much as trying to expel an anema on a bed pan. The patient who has to cough will do so whether he is lying in bed or standing up. The increased intra-abdominal pressure caused by the coughing is not greater in the erect position, but his ability to raise irritating mucous and so overcome his cough is better when he is out of bed.

RESULTS

There are numerous reports available that show comprehensive studies comparing patients treat-

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ed in the conventional manner with prolonged bed rest with those treated by early ambulation. These studies show comparative temperature and pulse curves, number of days in the hospital, weeks of convalescence, postoperative complications and time of return to productive employment. Routinely the advantage is with the early activated group.

1. Pulse and temperature curves return to normal earlier with early ambulation.

2. The average number of days in the hospital is from one-half to two-thirds as long.

3. There are less wound disruptions; less incisional hernias.

4. The time of convalescence before the return to productive employment is one-half as long.

5. Local wound complications like hematomas and infections are fewer. Pulmonary complications take place one-third as often.

6. With conventional treatment the necessity for repeated catheterizations are five times as frequent.

7. Patients who are allowed out of bed early to stand on the floor or sit on a commode rarely have trouble in voiding. The patient who is permitted to walk to a bathroom or commode will require much fewer enemas and not infrequently, will have normal bowel movements without any artificial stimulous.

8. Less morphine is required to relieve pain.

9. The patient will have a desire for and ability to take food much earlier and thereby have fewer gastro-intestinal complications and will be able to maintain blood chemistry at normal levels.

10. Less than one-half as many vascular complications such as venous stasis, thrombosis, thrombophlebitis, and emboli occur with early ambulation.

11. The psychological value of getting patients up early is striking. The patient's attitude toward his operation and his illness is markedly improved when he realizes that he can be up walking around within a few hours after he returns from surgery.

12. The economic value of early ambulation is an important one. It results in a marked saving in hospital cost to the patient; it provides many more available beds in our crowded hospitals, since these patients are able to leave the hospital so much earlier; and these patients return to productive employment so much sooner that it represents a real savings in money.

TECHNIQUE

Something should be said as to the technique of practicing early ambulation. The patient is helped to roll to the edge of the bed and then brought to a sitting position with the help of a nurse. If the casters are removed from the bed, he can easily step on to the floor or if the bed is still too high, he steps to a footstool and then to the floor. He is told to stand and take a few deep breaths. Frequently this will produce a cough. He is instructed to hold the abdomen tightly with his own hands and cough forcibly. If this tires him too much, he is immediately put back to bed. A couple of hours later he is again gotten up and allowed to walk around the bed. He is then at frequent intervals encouraged to get up and walk a little further each time. Within a couple of days he is usually able to walk to the bathroom and will usually be able to please himself as well as the nursing staff with his ability to void and defecate normally.

The technique of making and repairing incisions is outside the province of this paper. However, physiologically placed incisions and proper repair of the wounds is at least as important in the patient who is ambulated early as in the patient treated in the conventional manner. Men who are practicing early rising, avoid as much as possible, the use of absorbable suture material. It has been adequately shown that catgut produces marked tissue reaction; and the heavier the catgut the greater insult to tissue, with greater delay in the development of tissue strength. Cotton, silk, or wire, used as interrupted sutures cause much less tissue reaction and result in stronger wounds in less time.

However, accurate coaptation of tissue, good hemastasis, extreme care in prevention of infection and gentle manipulation of tissue are of greater importance than the nature of the material with which the wound is sutured.

Berylliosis

No specific treatment has been found for this disease, though every known means has been tried to improve the exchange of gases in the lungs. Most cases are treated symptomatically with oxygen therapy and rest as the chief standbys. High protein diet, vitamins, sedatives, etc., all have their place, but care of these cases can be, and is, very discouraging. Many cases show improvement, some are clinically well, a few show roentgenological improvement, but many are slowly, yet progressively, becoming worse, or at best, remaining stationary. Some have periods of improvement followed by recurrences of severe cough and dyspnea, possibly explained by secondary infection or cardiac decompensation. All show lowered vital capacity and decreased breath-holding time which may be used as a rough guide in evaluating symptomatic improvement. —Stanley A. Wilson, M. D., Salem, Massachusetts; Rhode Island Medical Journal, Vol. XXXI, No. 12, December, 1948.

Xeroderma Pigmentosum: Report of Occurrence in Two Japanese Siblings, With Secondary Epidermoid Carcinoma in One Case

PHILIP A. WEISMAN, M.D.

XERODERMA pigmentosum (Kaposi's disease) was described in 1870. Blackmar[1] states that the literature to 1920 contains only 80 cases. In American medical journals from 1924 to 1946 there appeared only 19 articles concerning the disease, most of them single case reports. As a U. S. Army Medical Officer in Japan I followed two Japanese children with this unusual disease who were patients of Dr. Noboru Yano, professor of dermatology at the Mie Medical College. This report is submitted as an addition to the literature and as further evidence of the role of heredity and intermarriage in this precancerous childhood affliction.

Xeroderma pigmentosum[2, 3] usually appears before the second year of life as a persistent erythema of the face, neck, and arms following exposure to sunlight, but differing from ordinary sunburn in that it takes longer to disappear. Hyperpigmentation frequently in the form of dark freckles, hyperkeratosis, atrophy of the epidermis, conjunctival hyperemia, and photophobia follow.

The disease is of especial interest since by the age of 6 or 7 years epidermoid carcinoma often appears, and melanotic cancer has been reported. The malignant changes have a predilection for the circumoral and circumorbital regions and appear to be primarily confined to the skin. Metastases to the lymph nodes and other organs are said to be infrequent.[4]

Xeroderma pigmentosum is believed to be inherited as a simple recessive characteristic, and several siblings may have the disease. It has been suggested[3] that the basic defect is an inherited sensitivity to ultraviolet rays. Interestingly enough, the disease has been reported in a full-blooded negress.[5]

Mental deficiency has been noted in some patients. Silberstein[6] ventured that the mental deficiency in his two cases may have been coincidental, but that the hypothesis offered by de Sanctis and Caccione[7] of a congenital defect in the ectodermal system resulting in premature senility of the skin and nervous system was attractive. I submit that the tremendous physical and emotional handicaps attending the ugly lesions of these unfortunate children may make the mental deficiency more apparent than real.

Treatment[2, 8, 9] is prophylactic and palliative, consisting of measures to protect ordinarily exposed surfaces from the rays of the sun. This is accomplished by the use of darkened rooms, tinted veils, spectacles, umbrellas, and protective ointments. Keratoses may be treated by fulguration or radiotherapy. Neoplastic lesions are excised. Homespun psychotherapy, love and security, will help to make the unhappy lives of these children more bearable.

Submitted June 4, 1948.

The Author

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REPORT OF CASES

Michio F. (Case 1), a 7-year-old Japanese male, was said to have been normal at birth and in good health until the age of 5 months, when he developed persistent erythema of the face. The erythema appeared and disappeared until the age of 2, when he was seen by Dr. Yano. Measles at this time had no apparent effect on his skin disease. By the age of 4 pigmentation had begun to appear on the face, and soon thereafter crusting and scaling. The diagnosis of xeroderma pigmentosum was suggested at this time. The patient was treated with ointment containing quinine and with occasional injections of vitamins A and C, and by the avoidance of sunlight. The treatment was ineffective.

In March, 1947, at the age of 7 years, a small, crusted papule developed over the right superciliary arch. When the crust was removed a granulating surface appeared. Biopsy was not performed. The papule disappeared with radium treatment. Also in March the patient developed bilateral conjunctivitis with symblepharon of the lower lids, which were freed surgically. Histologic examination of the conjunctival adhesions failed to reveal carcinoma. The patient was seen again in June, at which time no tumors were present.

In September, 1947, the patient first came to the Mie Medical College Hospital Clinic with the chief complaint of tumor of the left eyelid. The mother stated that the tumor had begun in August as a papule and grown slowly until about the 10th of September, when it began to enlarge very rapidly. The patient was admitted to the hospital September 29th for excision of the tumor.

Systems review was not remarkable except for the history of extreme intolerance to sunlight and also the presence of ascariasis. The pa-

tient was said by Dr. Yano to be mentally retarded to the age of 5 years.

Physical Examination: The patient was of average size and development compared with other boys his age in undernourished Japan. The left eye was obscured by a 5 centimeter in diameter, pedunculated, fungating, partially necrotic tumor of the lid so large that it precluded vision from the left eye (Figure I). The eye itself was not in-



Figure 1. (Case 1). Epidermoid carcinoma of left eyelid secondary to xeroderma pigmentosum. Note hyperpigmentation and keratoses characteristic of the latter disease.

volved, and vision was present when the tumor and lid were upheld. However, both eyes were angry red with conjunctivitis, and symblepharon of the left lower lid was present. The skin of the face, ears, and neck was discolored by a brownish pigment and disfigured with scaling, cutaneous atrophy, keratoses, and cicatrization. The skin of the chest and back were involved to a lesser extent. There was a slight eruption on both feet. The mucous membranes of the nose and throat were normal, and there were no palpable lymph glands in the neck. There were no remarkable findings on examination of the heart, lungs, abdomen, genitalia, nervous or skeletal systems.

Laboratory examination of blood, urine, and stool yielded normal findings except for a slight leukocytosis (9,800) and eosinophilia (11 per cent) and a moderately low hemoglobin (69 per cent with 4.3 million erythrocytes).

Course: On September 30th, under general ether anesthesia, the tumor was elliptically excised by Dr. Yano and replaced by a split thickness graft from the left thigh. Postoperatively a small papule on the left cheek was given radium treatment. On October 8th the skin graft was noted to be two-thirds necrotic. By October 15th the wound had contracted to 1.5 centimeters in diameter. The left palpebral fissure was narrowed, apparently by contraction of the lids. A new papule was discovered on the right cheek and treated with radium. By October 27th when the patient was discharged the radium treated papules had nearly disappeared, and the wound had epithelialized.

Pathologic Examination: The surgical specimen consisted of two pieces of extremely friable, partially necrotic tissue, torn apart in operation. On microscopic examination the Japanese pathologist described the following: Undifferentiated cylindrical cells at the root of the tumor, but no nests; a clumping of the cells and mixing with connective tissue, so that it had the appearance of a cylindrical cell cancer; toward the surface of the tumor a differentiation toward flat cells; a carcinoma of peculiar form intermediate between a squamous and a basal cell tumor. Numerous mitotic figures were present. The pathological diagnosis was "flat epithelial cancer without cornization." (The accuracy of the above description perhaps suffered from its free translation into English.)

FAMILY HISTORY

In view of the postulated simple recessive inheritance of this disease, the family history is interesting in its complicated pattern of intermarriage. Since it is customary for the Japanese to maintain in the village office careful family records, the history was easily traced back five generations (Figure 2). Consanguine unions oc-

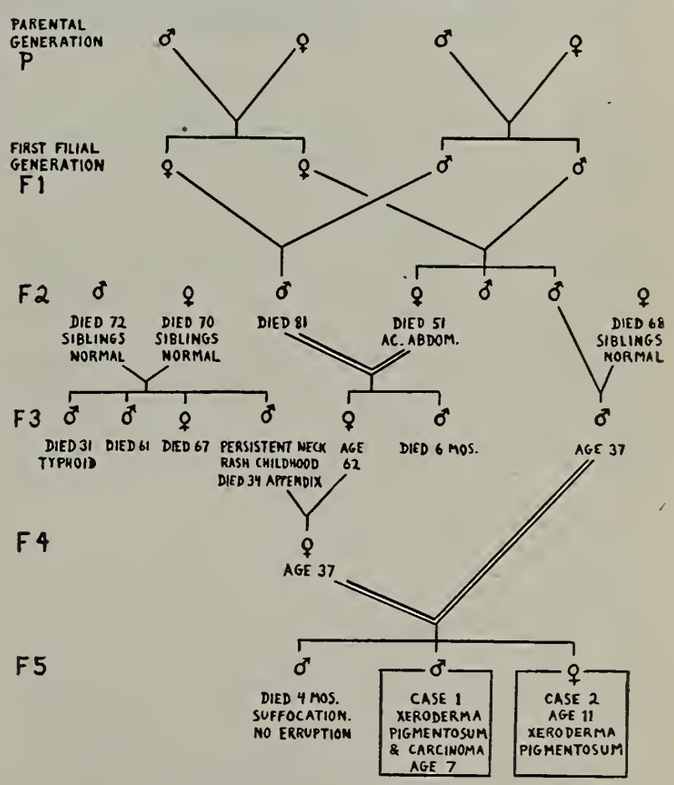


Figure 2. Diagrammatic family history of Japanese siblings with xeroderma pigmentosum. Double lines indicate consanguine marriages.

curred in the marriage of the patients' parents and also one set of great grandparents.

The patient's maternal grandfather was said to have had a persistent rash on the back of his neck during childhood, for which he had received an unflattering nickname. He is reported to have died of appendicitis at age 34.

A brother is reported to have died at the age of 4 months of suffocation, with no evidence of skin disease.

The patient had one living sibling, an older

sister, Michiko F. (Case 2), age 11 (Figure 3). Three and one-half months after birth she developed a rash on the face, followed shortly by crusting and scaling lesions, and by the age of one year, brownish pigmentation. The illness had continued ten years with remissions and exacerbations and the development of conjunctivitis. The diagnosis of xeroderma pigmentosum was made, and although carcinoma had not been demonstrated, a suspicious papule had appeared on the face, and the crusting, scaling, and conjunctivitis were more severe than in her brother. The girl was said by her mother and Dr. Yano to be of low intelligence but normal size and development.



Figure 3. (Cases 1 and 2). Xeroderma pigmentosum in Japanese siblings. Two months postoperatively the site of removal of the carcinoma and skin grafting on the left eyelid (Case 1), left, is healed. Note the characteristic marked photophobia in both children.

I last saw the children in December, 1947. The boy's wound was healed, and there was no local recurrence of the carcinoma. On the left cheek, however, was a suspicious ulcerated lesion. Cervical nodes were not abnormal. The condition of the girl was unchanged.

SUMMARY

Two cases of xeroderma pigmentosum in Japanese siblings are presented. In one of them epidermoid carcinoma occurred secondarily. Xeroderma pigmentosum is especially interesting in that it is an example of a precancerous lesion of childhood with a usually fatal outcome, inherited as a simple recessive characteristic.

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Hazards of the Uncontrolled Use of Bromides

Bromides have been used in therapy since 1840, and we find, in recent years, a useful drug becoming dangerous and even fatal in its effects. There are four distinct causes for this state of affairs. The first is that anyone is able to purchase bromides in any form in any dose and amount over the drug counter without the prescription of a physician. The second is that a patient may have a prescription for this drug filled repeatedly without the knowledge of his physician. A third cause lies in the fact that it is still not generally realized that bromides may produce severe intoxication, and the signs and symptoms of such intoxication are not recognized when they do appear. A fourth cause is that persons may purchase this drug without any check or hindrance on the part of the Public Health authorities in spite of repeated recommendations from the medical profession that this drug be placed in the same category as other narcotics and sedatives.

Many controlling factors appear to determine the accumulation of bromides to a toxic phase. Tissue and blood retention must vary, excretion rate is a variable, renal function is a factor as so also is diet, fluid intake and salt restriction. Bromide is a particularly dangerous drug when given to the aged arteriosclerotic, to those with renal or heart disease or to any patient who has been placed on a restricted salt or fluid intake. Retention of bromides in the tissues is encouraged in these cases, toxic symptoms appear more readily and elimination of the drug is more difficult. As in the case of other drugs, e. g. alcohol, it is a common observation that there are many healthy persons who will show, that to them bromides, even in medicinal doses, are a poison producing toxic signs in a short time period of their use. The importance of this subject is emphasized by the fact that in one month, 13 cases admitted to the Psychiatric Hospital, as suitable for observation and treatment, were diagnosed after admission as cases of Bromide Psychosis,—conditions created by the uncontrolled use of bromides.—Edward F. Brooks, M. D., Toronto; Bulletin of Vancouver Medical Assn., Vol. XXV, No. 1, October, 1948.

Prophylactic Administration of Wheat Germ Oil Concentrate in Pregnancy; A Clinical Analysis

WYNNE M. SILBERNAGEL, M.D., and JAMES B. PATTERSON, M.D.

THE oral treatment of habitual and spontaneous abortion with a wheat germ oil concentrate* was outlined in a previous publication.[1]

The present study deals with the use of wheat germ oil concentrate as a prophylactic agent. Two hundred and forty-five consecutive obstetric patients were given the medication. All received the medication for at least 180 days.

A large number of consecutive cases, carefully observed and clinically evaluated compares favorably with the requirements of a rigid scientific study. A number of investigators[2,3,4] have agreed that 16 of every 100 patients threaten to abort in the first trimester. Our own experience with more than 3,000 cases previous to this study confirms that approximately 16 per cent threaten to abort.

This study reveals that 24 patients, or 9 per cent, threatened to abort, and of these, 10 went on to term. Fourteen, or 5.8 per cent aborted. These figures can be evaluated when compared to Hudson and Rucker's study of 1,000 patients.[5] They reported 94 patients aborted, 68 threatened to abort—a total of 15.4 per cent. Thirty-eight of the 68 who threatened to abort, did abort, a total of 13.2 per cent.

Our study also reveals a lower rate of toxemias and prematurity as compared to the expected rate.

The high percentage of fetal loss before the period of viability is attained constitutes one of our largest medical and economic problems. The preservation of these lives is a challenge we must meet.

It has been stated that in 25 per cent of all pregnancies, spontaneous termination threatens before the period of viability has been reached. Three groups working independently and reporting on the abortion rate indicated the rate to be 16 per cent in 3,773 pregnancies.[6,7,8]

Many causes for spontaneous abortion have been suggested. The pathologic, malformed or "blighted" ovum has been held responsible by some observers for the majority of spontaneous abortions. The period of gestation in which the abortion occurs influences the abortion rate.[9]

According to Mall, approximately 12 per cent of patients who exhibit signs of threatened abortion may deliver malformed children. This view has not been confirmed by other observers. It should be noted that recent observations show that many of these fetal defects may be due to some of the acute exanthemata affecting the mother during the first trimester of her pregnancy.

Many studies have been reported concerning the management of threatened abortion. Some obstetricians believe that the supposed high incidence of pathology in the conceptus indicates that treatment is either of no avail or in many cases is even contraindicated.

It has been stated that some threatened abortions are the end results of already interrupted pregnancies and are actually missed abortions. Therapy of any type would be of no value in this group of patients. Malpas[10] believes that it is not until three successive abortions have occurred, that random causes may be excluded and a patient classified as an habitual aborter. Bachrach[11] disagrees with this view. He has shown that experiments with wheat germ oil, which he calls vitamin E, have a direct effect in making possible full term births among women who had two or more consecutive abortions.

We believe that the withholding of therapy may result in the loss of pregnancies which otherwise might have been salvaged.

Since we are interested in the preservation of life whether embryonic, fetal or postnatal, we should try to find a method of preventing spontaneous abortion, rather than to search for a method of stopping, after it has begun, this frequently costly and disastrous process. Thus, our

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*The wheat germ oil concentrate was obtained from wheat germ oil which was solvent extracted by ethylene dichloride. It is a fraction of wheat germ oil containing the non-saponifiable factors. Using the arbitrary measurement of tocopherol content as an indicator the fraction represented an eight fold concentrate of wheat germ oil. The wheat germ oil concentrate was provided by the VioBin Corporation of Monticello, Illinois.

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interest has been directed toward the finding of a prophylactic procedure.

In this respect the findings of Vogt-Möeller, Currie and others[12,13,14] in the treatment of habitual abortion have not received the consideration they deserve. These workers used a wheat germ oil concentrate in the management of habitual and threatened abortion. Since the wheat germ oil concentrate contains vitamin E, it has been erroneously assumed that the results obtained by these authors were due to vitamin E. No one since has been able to duplicate the results of these workers by the oral administration of vitamin E. Our results, using wheat germ oil concentrate, tend to confirm the findings of Vogt-Möeller and Currie. We have gone further in that the treatment has been given to a sufficient number of consecutive patients to reveal that we have here an effective prophylactic agent.

PATIENTS STUDIED

Two hundred forty-five patients were observed. Each was given two 3-minim capsules of wheat germ oil concentrate daily throughout the entire pregnancy.

Of this series of 245 patients, 24 or 9 per cent, threatened to abort. Ten patients of the 24 went on to pregnancy at term. Fourteen, or 5.8 per cent, aborted. No malformed infants were delivered. Sixteen per cent of the patients who aborted expelled fetuses and/or placentas which showed gross developmental deficiencies.

RH FACTOR

Thirty-one patients were Rh negative. Six husbands were Rh negative. The possibility of erythroblastosis due to Rh incompatibility was present in only 25 patients (10 per cent). No patient in this group had a baby with erythroblastosis and no patient had an increased Rh antibody titer. One patient in this group had a non-toxemic abruptio placenta with a stillborn premature baby. One patient with a mild pre-eclampsia [Group B I (a) toxemia] had an abruptio placenta. The baby succumbed twenty-four hours after delivery. This was an extra chorial pregnancy and the baby was poorly developed and was classified as a group 3 premature (1500-2000 Gms.).

PREMATURITY

The premature babies were classified according to the standards of the American Academy of Pediatrics. There were eight premature babies including one set of twins. The percentage of prematurity was 2.8 per cent. Two of these prematures were mentioned in the Rh group. One baby, a Group II premature (1001-1500 Gms.) was delivered of a mother with a severe pre-eclamptic toxemia. There was one Group I (1000 Gms. or less) which survived; one Group II baby which succumbed; four Group III (1501-2000 Gms.) babies, two of whom survived, one of whom died in the neonatal period, and one of whom was stillborn.

The incidence of prematurity in all groups of mothers taking wheat germ oil concentrate was eight patients or 2.8 per cent. Five of these babies or 62.5 per cent survived. The incidence of prematurity, as observed by Brown, et al.,[15] after a study of 13,399 mothers and infants, was 7 per cent. Eastman[16] in a review of 28,493 deliveries, reported the incidence of prematurity to be 11.7 per cent.

Prematurity is responsible for one-half of all neonatal deaths. Faulty nutrition deserves serious consideration as a possible cause of miscarriage, stillbirths, prematurity, and pregnancy toxemias.

TOXEMIAS OF PREGNANCY

Nausea and vomiting of pregnancy occurred in 74 patients or 30 per cent. This condition was readily controlled by the intravenous administration of pyridoxine HCL.[17] In 1934, Misset[18] reported that the incidence of late toxemias was increased among patients having nausea and vomiting in the first trimester. Thus we are unable to determine to what extent the wheat germ oil concentrate aided in the lowering of the incidence of toxemias. In this series only 10 patients or 4 per cent developed toxemias of pregnancy. Six of these were primagravida and four were multigravida. Eight of these were pre-eclamptics [Group B I (a)]; one severe pre-eclamptic [Group B I (b)], and one eclamptic [Group B II (a)]. The incidence of toxemia in this series, excluding nausea and vomiting of pregnancy, was 4 per cent. This is considerably lower than the usually reported 10 per cent.[19]

DISCUSSION

These results cannot be attributed to the tocopherols. The total tocopherols in a daily treatment (two 3-minim capsules) is eight milligrams. The average American diet provides much more tocopherol to the patient.

The presumption that wheat germ oil concentrate contains, exclusive of the tocopherols, a substance of significance to the reproductive mechanism, may be seen in the studies of Ebbs, Tisdall, et al. [20,21] In the Toronto studies of these workers poor diets with supplementary rations of milk, cheese, oranges, tomatoes, wheat germ, and vitamin D were administered with these results:

TABLE I

	Premature Birth	Miscarriage	Stillbirth
Poor diets	8.%	6.%	3.4%
Supplemented diets	2.2%	0.0%	0.0%
Good diets	3.%	1.2%	0.6%

Only by assuming that there were some factors present in the supplemented diets that were not present in the good diets can the remarkable

absence of miscarriages and stillbirths be explained. The supplemented diets differed only from the good diets in that they contained wheat germ.

We do not suggest that the administration of wheat germ oil concentrate is of value in the prevention of erythroblastosis fetalis. Of the patients in whom the possibility of erythroblastosis existed—12 primigravida and 13 multigravida—erythroblastosis did not occur. Also Rh incompatibility was not responsible for any of the cases of early or late abortion, prematurity or toxemia.

SUMMARY

Two hundred forty-five consecutive obstetric patients were given wheat germ oil prophylactically.

The expected threatened abortion rate is 16 per cent or higher. Sixteen per cent of the patients who threaten and who do abort expel fetuses and/or placentas which show gross developmental deficiencies.

The results of the prophylactic administration of wheat germ oil concentrate are as follows:

1. Twenty-four patients (9 per cent) threatened to abort. Ten patients of the twenty-four went on to pregnancy at term and fourteen patients (5.8 per cent) aborted.

2. The possibility of erythroblastosis due to Rh incompatibility was present in twenty-five patients (10 per cent). No patient had an increased Rh antibody titer, and none had an erythroblastotic baby.

3. The percentage of prematurity was 2.8 per cent. The percentage of survival of the premature babies was 62.5 per cent.

4. Seventy-four patients or 30 per cent had nausea and vomiting of pregnancy.

5. Ten patients or 4 per cent developed toxemias of pregnancy.

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Rheumatic Fever Control

The majority of children were receiving inadequate diets at the time they developed the attack of rheumatic fever which brought them under observation. The degree of deficiency of the diet was related to the incidence and degree of heart damage. The diet as a whole is important, but the most commonly deficient nutrients were protein, vitamin D, thiamin, and the minerals.

Jackson points out that rheumatic families who have been helped to provide a high level of environmental care for their children should have fewer siblings who develop the disease, and that among the next generation of children there should be a lower incidence of rheumatic fever.

This study indicates that every effort should be made toward improvement of the general living conditions of rheumatic children. This involves a different concept of prophylaxis and calls for different skills. It requires much more time, knowledge, and patience to instruct a mother how to care for and feed her child than to instruct her in giving medication. Where formerly the physician and his nurse or technician could prescribe chemotherapy for prophylaxis and observe patients for toxicity, planning for proper environmental care and adequate diet for the rheumatic child calls for additional personnel. This sociologic approach requires contribution from public health nurses, nutritionists, and medical social workers. The role of the physician is broadened further as he becomes more concerned with education. His prestige is enhanced through community service and he continues as captain of the team of workers whose objective it is to protect the rheumatic child. Medicine will do well to pause for thorough exploration of this recent milestone in rheumatic fever control.—Facts About Nutrition. N. Y. State Jrnl. of Medicine, Vol. 49, No. 1, January, 1949.

Positive Pressure

PHILIP KATZ, M. D.

IN addition to the type of gas used in inhalation therapy, the technique in its administration is of paramount importance in certain diseases for which the gases are indicated.

Positive pressure therapy was used as early as 1897 by Norton in the treatment of pulmonary edema, but it was the work of Barach, Martin and Eckman which popularized the method and established the clinical application and usefulness of positive pressure and the physiological basis for its use in obstructive dyspnea and acute pulmonary edema.

Barach and his associates showed what takes place in obstructive dyspnea, whether due to bronchial asthma or to lesions in the upper air passages (such as swelling of the mucous membrane due to infection, tumors, enlarged glands of the larynx, bronchi, or trachea) or tracheal stenosis from other causes. When air is breathed through a constricted lumen, there is an almost instantaneous sensation of dyspnea due to an increase in effort necessary to draw air into the lungs. This produces a pathological elevation in the negative intrapulmonary pressure in the inspiratory cycle, in an effort to suck air past the obstruction. If this continues, it exercises a cupping action on the pulmonary capillaries and bronchi. This causes an exudation of serum into the alveoli and an increase of mucous from the bronchial mucous membrane. The lungs become progressively congested and edematous and pulmonary edema develops with its accompanying anoxia and vicious cycle.

In pulmonary edema, the transudation of serous fluid from the capillaries into the alveoli produces suffocation and is one of the most common causes of anoxic anoxia.

The causes of the edema may be varied, depending upon the underlying disease.

1. In heart disease it is primarily due to left ventricular failure. Here, because of the disparity between the force of the right and left ventricles, blood accumulates in the lungs, increased capillary pressure develops followed by oozing of serum into the alveoli.

2. In pneumonia it is the result of increased capillary permeability due to inflammation, anoxia, and probably at times to left ventricular insufficiency.

3. As stated above, in bronchial asthma or laryngeal obstruction, it is due to a persistent pathologically elevated negative pressure within the chest. Or if the laryngeal obstruction is suddenly terminated by tracheotomy, or in asthma by giving morphine, there is an abrupt termination of expiratory effort and a consequent loss of backward pressure on the pulmonary capillaries.

4. In gas poisoning, it is due to the action of the gas on the alveolar epithelium and capillary permeability.

5. In shock it is due to myocardial insufficiency with decreased cardiac output, associated with peripheral arterial vasoconstriction because of decreased blood volume. This takes place before there is a change in venous pressure. There is thus produced an inbalance in pulmonary circulation, resulting in pulmonary engorgement and development of pulmonary edema. This is also aggravated by the anoxia accompanying shock which produces capillary permeability.

6. Eaton has recently shown in some brilliant experiments that following a peripheral blood loss of 25 per cent, there results a circulatory imbalance characterized by low peripheral arterial pressure, and a transient elevation of both pulmonary artery pressure and peripheral venous pressure. This in time increases capillary pressure in the lung and edema results. In addition there is a decrease in cardiac output, a lengthening of circulation time, anoxia of circulating blood, an increase in capillary permeability, congestion of the pulmonary capillary bed, and pulmonary edema as shown both microscopically and by dessication experiments. In other words, Eaton has been able to produce by hemorrhage all of the circulatory changes that Moon describes as characteristic of shock.

PHYSIOLOGICAL CHANGES

Barach and his associates have shown in their most recent work that the following physiological changes take place under pressure breathing.

1. The functional residual air is increased almost 400 cc., and the minute and tidal volumes are elevated considerably.

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2. The venous pressure was elevated (by the use of 6 cm. of water positive pressure.)

3. The circulation time is prolonged in patients with heart disease as much as 15 seconds. This may be of benefit in left ventricular failure because this results in a decrease in volume of blood that the heart has to handle and is comparable to tourniquets applied to extremities and to phlebotomy.

4. The cardiac output is decreased as determined by the Fick Principle.

5. The volume of the pulse is reduced.

In addition to this action on the circulatory system, positive pressure breathing decreases the pathologically elevated intrapleural negative pressure occurring in obstructive dyspnea during the inspiratory cycle. Inhalation of oxygen or oxygen and helium under pressure will overcome the suction action and also decrease the amount of dyspnea. During expiration it tends to maintain a wider lumen of the bronchial tree and this allows the gases to escape more easily. But what is even more important is that positive pressure tends to act as a tampon on the pulmonary capillaries. Its effectiveness is due to the direct opposing pressure on the capillaries, counteracting the internal hydrostatic pressure in the pulmonary capillaries and thus preventing the oozing of serum into the alveoli. This is its action in clearing the lungs in pulmonary edema.

I think at this time it is important to emphasize the contraindications to the use of positive pressure. Having outlined the physiological action of the pressure breathing, it can be seen that it is contraindicated in shock. It would only increase the extent of the shock because it would intensify the already decreased cardiac output, decrease the venous return, prolong the circulation time, tend to further anoxia, etc. Therefore, it is also contraindicated in severe hemorrhage.

Ryder and Kehoe in their recent article in *Anesthesiology* in discussing the hazards of pressure breathing, have brought out an interesting point. They state that in congestive heart failure, positive pressure, because it decreases venous return, is in effect a way of applying tourniquets, not only to the extremities, but also to the head and trunk. This may be salutory, but if the failure is associated with myocardial infarction, attempts to clear the pulmonary edema by pressure breathing may increase the amount of shock that is already present.

CLASSIFICATION

Pressure breathing may be divided into two main classifications:

Continuous, when an attempt is made to maintain a constant pressure during inspiration and expiration.

Intermittent, when a greater pressure is deliberately achieved, either during inspiration or expiration.

Various apparatus for pressure breathing are in use, most of which have been devised by Barach and his associates.

The helium-oxygen hood is the most effective one for giving oxygen or oxygen and helium, with or without positive pressure. The percentage of the mixture can be accurately controlled as can the positive pressure, both during inspiration and expiration. It consists of a conditioning cabinet containing a carbon dioxide absorber, rheostat for the control of air flow and temperature, connected to a plastic hood which fits over the patient's head and made airtight by a soft rubber collar. It is very comfortable and efficient.

The metered mask devised by Barach and Molomut is a face mask, quite comfortable, to which is attached a 1000 cc. soft rubber bag. Positive pressure is controlled by means of a device attached to the expiratory valve having five orifices of various sizes, the smallest orifice giving a pressure of 4 cm. of water during quiet breathing. However, in patients with dyspnea, a much higher pressure may develop if the 4 cm. orifice is used. The higher pressures may be used at first but as soon as clearance of the edema is evident, the pressure is reduced to 1 or 2 cm. for one to three hours, to be increased again if necessary.

The metered mask is the simplest and most convenient to use.

H. L. Motley, at the recent meeting of the American Society of Anesthesiologists in New York, described a new valve called the Pneumatic Balance Resuscitator. This valve was developed at the Aero-Medical Laboratory at Wright Field for giving intermittent positive pressure where artificial respiration may be needed. This valve, of simple construction and foolproof, converts continuous positive pressure into intermittent pressure. The physiological workup of this valve coincides with the findings described above. It has been used in cases of pulmonary edema and obstructive dyspnea, and has given excellent results.

In summarizing, positive pressure therapy, as a rule employing oxygen or oxygen and helium, has not become as widespread in its use as it should be.

It is indicated in pulmonary edema and obstructive dyspnea.

The physiological basis of its action has been described, and because of that action, it has its contraindications which must be kept in mind if disaster is to be avoided.

Oxygen Therapy

FRED BROSIUS, M.D.

IN reviewing the abundant literature on oxygen therapy, one is impressed by the impossibility of properly covering the subject in the time alloted to this paper. Therefore, I shall present a few conclusions that, I hope, may be of value to the internist as well as the anesthesiologist.

Oxygen, as we know, is necessary for the maintenance of life. The human body will tolerate variations in the oxygen and carbondioxide content of inspired atmospheres, provided the concentration of oxygen is not below 20 per cent. The tissue change, known to us as metabolism, requires oxygen to facilitate combustion and the release of energy essential to vital physiological processes. We are all familiar with the diseases attributed to faulty metabolism and by the role played by oxygen in these conditions. In glandular dysfunction as well as diseases of the respiratory or circulatory systems, there is a demand for an increased percentage of oxygen.

The air-hunger in the anemias is the attempt of nature to supply sufficient oxygen to the starving tissues when the transportation facilities are inadequate. Not many years ago, transfusions and the resort to oxygen therapy was considered only in desperation. Now, fresh blood and oxygen are freely used in hastening the repair of diseased or traumatized tissue. We are told that the central nervous system requires twice the amount of oxygenated blood as does other cellular structures. The return to rationality of patients under oxygen therapy is gratifying to the internist and well repays him for its use. The period of convalescence is shortened in both medical and surgical cases.

Under normal atmospheric conditions, the healthy individual is not conscious of respiratory effort unless he is subjected to physical exertion. In many respects, a patient suffering from anoxemia, from whatever cause, resembles a person under muscular strain. In both instances the rate and depth of respiration is increased as the circulatory system struggles to deliver sufficient oxygen to the cells. If the heart is impaired, the pump cannot meet the demand for oxygen-enriched blood and some means must be provided for increasing the oxygen content of inspired air. When the decision is made to institute oxygen therapy, the first consideration is the necessary oxygen dosage to relieve the respiratory effort and cardiac labor. Physiologically, the atmosphere should contain a concentration of oxygen sufficient to overcome the arterial anoxia.

Oxygen therapy is similar to other types of medication. The dosage should be sufficient to obtain the desired physiological effect. In extreme cases, 100 per cent oxygen may be continued for hours without harm. Army aviators breathe this concentration for an hour before attempting altitude flights of 25,000 feet or higher. Pressurized cabins in aviation and submarine activities provide an atmosphere comparable to that at sea level. The similarity between oxygen chambers used in oxygen therapy and the pressurized cabins in aviation is striking. Air conditioning that provides humidification, carbon dioxide absorption, temperature and oxygen regulation, is common to both. As dehydrated oxygen is irritating to the nasopharynx of lower animals, the proper humidification of oxygen mixtures, given to man, adds to his comfort.

MEANS OF ADMINISTRATION

In choosing the means of oxygen administration, the simplest mechanism meeting the need of the individual patient is essential. Intraperitoneal, intravenous, intramuscular and subcutaneous routes have been discarded for the practical inhalation method of oxygen therapy. Oxygen chambers are ideal for both medical and surgical patients but, unfortunately, cannot be provided in every hospital. Tents are effective but cumbersome. In these days of limited nursing personnel, the nasopharyngeal tube is quite satisfactory and permits complete bedside nursing. The self-administering oxygen bag with a nasoral mask is quite popular while the apparatus, patterned after the circle filter used in anesthesia, permits the inhalation of pure oxygen and the absorption of carbon dioxide exhaled.

In those cases where the respiratory struggle is due to tracheal or bronchial obstruction, helium

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may be added to the oxygen mixture up to 80 per cent until the dyspnea is relieved.

In anesthesia, it is imperative that a constant flow of oxygen be maintained in order to supply the metabolic need of the patient. Gwathmey stated that oxygen increases the value of all inhalation anesthetics in rendering their administration safe to the patient without decreasing the anesthetic value. With all respect, I would amend that statement by omitting the word "inhalation." Oxygen is indicated in all types of anesthesia. Cyanosis has no place in modern anesthesiology. Gaseous anesthetics, being carried in the blood stream, may crowd out the life-giving oxygen and cause disaster if the anesthetist neglects oxygenation.

ADDITIONAL STIMULATION

Anemics and exsanguinated patients require generous amounts of oxygen. Those in shock demand high oxygen concentration as they are suffering from the most severe form of tissue anoxia. In this day of balanced anesthesia, with the aid of pentothal, the same stage of surgical anesthesia may be maintained without crowding the gaseous anesthetics. Utilization of the exhaled carbon dioxide as a respiratory stimulant, oxygenation may be insured throughout the surgical procedure. In those cases where there is need for additional stimulation of respiration, metrozol and caffein are valuable aids. Curare has proven of untold value to the surgical team but the respiratory depression that follows its use, may require rhythmic, manual compression of the breathing bag to insure oxygenation.

When curare is administered to facilitate closing the abdominal incision, and the respiratory depression extends beyond the time of need, the use of prostigmin is indicated in order to have the patient breathing normally when leaving surgery. The old admonition, "Never move a surgical patient until he is breathing freely and deeply," is as true as when it was uttered years ago. Dr. Gwathmey once stated, "If the anesthetic has been properly administered, all reflexes should be present as the patient is placed in bed." We anesthesiologists realize that, when the surgical schedule is crowded, the element of time is a potent factor. We cannot give the postoperative patient the personal attention we desire, but, before releasing the individual to the care of a competent nurse, an open air-way is established and respirations free.

Oxygen should be administered in all spinal anesthesias. If the patient is conscious, a constant breeze of oxygen, discharged from the tubing to the naso-oral region, adds to his comfort and safety. Occasional deep breaths of oxygen and carbon dioxide in a ratio of 95 to 5 per cent overcomes nausea and psychic depressions.

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Electrocardiograph in General Practice

Various types of cardiac arrhythmias are definitely identified by the electrocardiogram. Auricular flutter and auricular and ventricular tachycardia are differentiated with difficulty without an electrocardiogram; likewise, auricular fibrillation from various types of frequently recurring extrasystoles; also from various types of heart block. Furthermore, a familiarity with electrocardiography will enable the clinician to identify the arrhythmias at the bedside without having a tracing made. The aid given by electrocardiography, in identifying irregular heart action, is pre-eminent and is valuable in acute diagnosis and management of the arrhythmias.

However important this may be, the information furnished by the electrocardiogram, regarding the status of the myocardium and its circulation, has far surpassed its value in any other phase of cardiology. The electrical impulse, activating the heart muscle, is transmitted through it in a characteristic way. These changes of potential cause the galvonometer string to deviate in certain ways. A record of these deviations forms the normal electrocardiogram. The myocardium with a defective circulation causes a deficiency of oxygen (temporary or permanent) or anoxemia. But whether due to a temporary inadequate circulation or to a permanently obstructed circulation, resulting in infarction or fibrosis, the electrocardiographic patterns depend on the changes of potential in the transmission of the electrical impulse through this modified or destroyed myocardium. Recent EKG research has been largely devoted to this field. In the more definitely established cases of heart disease with gross cardiac enlargement the electrocardiographic evidence is not necessary, but may be of interest. In doubtful cases this may be helpful.—F. W. Niehaus, M. D., Omaha; Neb. State Med. Jrnl., Vol. 34, No. 1, Jan., 1949.

The Use of Tetra-Ethyl-Ammonium Chloride in Causalgia and Livedo Reticularis

BERT SELIGMAN, M. D.

TETRA-ETHYL ammonium chloride is no longer a medical curiosity. Its extensive experimental use and subsequent utilization by many qualified research and clinic groups under control conditions has firmly established it as a diagnostic and therapeutic agent. That tetra-ethyl ammonium chloride temporarily and partially blocks the transmission of sympathetic and parasympathetic nerve motor impulses through autonomic ganglia has been shown by the work of Lyons[1] and associates. Two clinical entities that are benefited by the use of this drug are causalgia and livedo reticularis. Causalgia is produced at the time of injury by sensory nerve filaments from whence originate the impulses that produce reflex stimulation of the anterior horn cells and sympathetic motor cells in the lateral horn.[2] Livedo reticularis is produced by a narrowing, either organic or functional, of the arterioles with dilatation of the capillaries and venules. Since sympathectomy results in change of color from livid to pink, it is to be assumed that the condition in the arterioles is predominantly of a vasospastic nature rather than of an organic nature.[3] It is not to be assumed that all cases of these two pathologic processes are benefited by tetra-ethyl ammonium chloride, but in certain selected cases a favorable result may be expected. The two cases presented below fall into this category.

CAUSALGIA

Mrs. F. F., aged 22, suffered a traumatic amputation of the tip of the middle finger of the right hand on October 3, 1946. Excellent healing followed. Definite evidence of impairment of circulation was manifested in about a month by a finger which was blue in color, cold to the touch and very moist on inspection. The patient stated that even light palpation of the involved digit produced such excruciating pain that she constantly carried her right hand in the palm of her left hand to prevent contact. She also carried a moistened handkerchief to wrap around her right hand stating that sometimes even a slight breeze on her involved finger produced paroxysms of pain and the handkerchief minimized this. Due to all these efforts to protect her right middle finger the patient adopted moderate flexion of her ring and little fingers and on her initial examination this was very apparent. The patient was first seen on April 10, 1947, approximately six months after she had sustained her injury. The physical examination was essentially negative except for the right hand which was encased in a moist handkerchief. Upon removing this the hand presented the following: All fingers except the middle finger were pink, warm, and dry. The middle finger was cold, moist and blue. There was a moderate flexion deformity of the ring and little fingers, and even light touch to the distal portion of the finger produced severe pain. Dermalor temperature readings revealed a difference of five degrees between the involved finger and the other four. After the examination the patient was given tetra-ethyl ammonium chloride, 5 cc. I.V., and the response was not only dramatic but gratifying. The usual effects of the drug were noted and in addition the middle finger began to pink up in about five minutes. At the same time the digit became warmer and dryer. At the end of sixty minutes the finger had the same appearance as the other fingers and of equal importance it was now possible to examine the finger with any amount of roughness without the slightest pain except for very mild pain at the site of the amputation. The patient was seen the following week on April 15, 1947. The finger was cold, not quite as blue as formerly and slightly painful to touch. She was again given 5 cc. of tetra-ethyl ammonium chloride, I.V., with production of a warm dry, pink, painless finger. She was given 5 cc. again on April 21 and April 28, and when seen on May 24, was so nearly restored to normal that further treatment was deemed unnecessary. On June 28, 1947, when last seen the finger was still warm, pink, and dry, no pain could be elicited on pressure or palpation, and the temperature readings of the fingers were approximately the same.

LIVEDO RETICULARIS

Miss R. S., aged 31, was first seen on September 25, 1947, with a chief complaint of numbness of her feet for the past ten years. In addition, she stated that she had pain in the calves when walking, night toe cramps, and perpetually cold feet. She stated that in the winter her feet became so cold that she found it necessary to wear several pairs of heavy socks with very little real relief. Physical examination revealed a moderately obese female with a blood pressure of 138/84, good dorsalis pedis and posterior tibial artery pulsations and a marble purple mottling of both lower extremities starting on the dorsum of the feet and extending up to the thighs where

The Author

● Dr. Seligman, Toledo, Ohio, is a graduate of Wayne University College of Medicine, Detroit, 1936; and is on surgical service, Flower and Maumee Valley Hospitals, Toledo.

Submitted April 13, 1948.

Tetra-ethyl ammonium chloride under the trade name of "Etamon" was furnished by Parke, Davis & Co., through the courtesy of Dr. E. C. Vonder Heide.

it faded out. She was given 5 cc. of tetra-ethyl ammonium chloride, I.V., on September 26, 1947, with an immediate response as manifested by pink, dry, and warm feet and legs. She returned in three days and stated that for the first time in ten years the lower extremities felt as if they were a part of her. The mottling had definitely decreased in intensity and she was given 5 cc. of tetra-ethyl ammonium chloride again on the twenty-ninth of September and the ninth, sixteenth, twenty-third, and thirtieth of October, each time with more improvement and each time having a more sustained clearing up of the process. She was asymptomatic until December 3, when there was a mild degree of coldness, mottling, and numbness. She was given 5 cc. of tetra-ethyl ammonium chloride and again on the tenth and eighteenth of December. She was seen again on January 7 and 14 and her symptoms had abated to such a degree that it was decided that further treatment was unnecessary. On her last examination there was no evidence of mottling, her feet were reasonably warm and the numbness had not been present for eight weeks.

CONCLUSION

Two cases are presented, one of causalgia, and one of livedo reticularis. They are typical cases and the effect of tetra-ethyl ammonium chloride as a therapeutic measure in each is noted. An excellent result was achieved in both.

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Adjustments to Age

Coffee, tea, tobacco and alcohol are often tabooed for older patients with no more real reason than the motive which, according to Macaulay, prompted the Puritans to forbid bear-baiting: not that it gave pain to the bear but that it afforded pleasure to the spectators. Except in occasional cases, the moderate use of these substances is probably not harmful; alcohol, in fact, is often employed therapeutically for its vasodilating effect, and caffeine is likewise a vasodilator.

One real hazard to older patients is that of obesity. This may result from an increase in the carbohydrate intake and a decrease in the amount of exercise taken. Excessive thinness is far less dangerous, but it too may occur. For most people, however, especially those past middle age, dietary advice may be summed up thus: Don't eat too much carbohydrate; don't eat too much fat; don't eat too much protein; don't eat too much—'period.'—Wingate M. Johnson, M. D., Winston-Salem, N. C., Medical Annals of D. C., Vol. XVII, No. 12, December, 1948.

KEEPING UP WITH MEDICINE

• PREVENTION of "winter itch" is simple and easy. It is usually caused by the drying effect of the weather and our methods of heating, aided and abetted by too much soap water bathing.

* * *

• THE right heart tolerates an overload less easily than the left.

* * *

• ANYONE suffering from a lack of sleep is potentially a nervous system.

* * *

• IN the diagnosis of Brucellosis, the laboratory not infrequently provides all too little aid in the diagnosis.

* * *

• THEY now say that some degree of hydroureter and hydronephrosis is physiological in pregnancy.

* * *

• THE ideal urinary antiseptic is yet to be discovered.

* * *

• NOT only can an aging population account for the great increase in the incidence of degenerative disease but so can the continuous selection against long-wearing tissues in our bodies. It was not so long ago that only 25 out of 100 babies born reached the age of 21 but now more than 85 do.

* * *

• SUCCESS or failure in the treatment of patients with seizures depends almost wholly on the control of the attacks. Hence the value of new anti-convulsants.

* * *

• WHEN we determine the concentration of the blood sugar we are really dealing with an equilibrium.

* * *

• THE rice diet for hypertension is certainly not adequate for the long pull.

* * *

• MANY notable contributions to the advancement of science have been made by brilliant interpretations of accidental observations.

* * *

• THE discovery of a nodule in the thyroid should be regarded with the same seriousness as a lump in the breast.

* * *

• NO hormone is to be given with hope of its stimulating its production by the patient.

* * *

• IN all cases of pleursy with effusion, the etiological factor of an abdominal lesion must be considered.—J. F.

The Care of Hand Injuries: Requirements of Early Definitive Treatment

THE general requirements for proper early definitive care are:

A. Thorough evaluation of the injury.

1. Determination of infection status; whether the wound is relatively clean, grossly contaminated, or with infection established.
2. General nature of the wound; i. e., contusion, abrasion, burn, incised wound, lacerated wound, crushing wound, puncture wound, tooth wound, imbedded foreign body, fracture, compound fracture, amputation or combined injuries.
3. Evaluation of structural damage.

B. Adequate facilities and equipment.

1. Each hospital or clinic should have at least one surgeon who is thoroughly familiar with the anatomy and physiology of the hand and who is prepared to undertake the early treatment of its major injuries.
2. Such treatment should be rendered under strictly aseptic conditions, preferably in an operating room, with careful adherence to aseptic technic in the matter of scrubbing, draping, masking, and the use of gloves.
3. An adequate supply of appropriate instruments.
4. Sufficient assistance to assure good exposure.
5. Good lighting.
6. Provision of a bloodless field by means of pneumatic tourniquet or blood pressure cuff.
7. Complete anesthesia for the patient, preferably by general anesthetic.

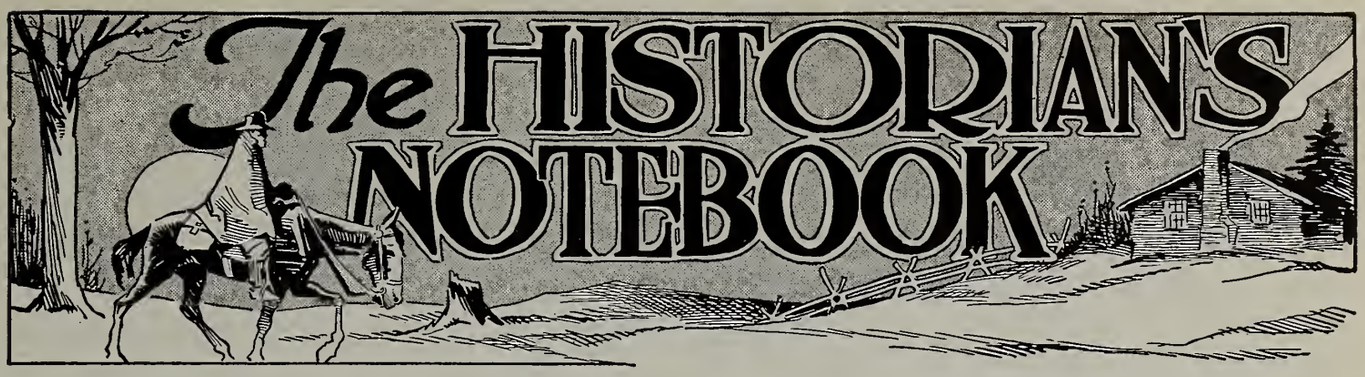
C. Application of appropriate treatment.

1. Thorough cleansing of a wide area around the wound with the wound protected. (Entire hand and forearm). Shaving, soap and water scrub.
2. Thorough cleansing of the immediate wound area, preferably with soap and water or a bland detergent. Antiseptics should not be used in or on the wound.
3. Careful inspection of the wound and assurance of adequate exposure, by additional incision if necessary, closely paralleling natural creases.
4. Thorough toilet of the wound, removing, under inspection, all foreign matter. Excision, by sharp and careful dissection, of all completely devitalized or grossly soiled tissue in the wound surface. It is essential that the greatest care be exercised to spare all tissues that may be viable, particularly skin, tendon, nerve and bone fragments.
5. Assurance of hemostasis by ligation of major injured vessels.
6. Repair of injured nerves by end-to-end union with fine interrupted perineural sutures. The uniting of divided digital nerves is important to future function.
7. Repair of other soft tissue injuries, where appropriate; i e., in clean wounds of short duration, well-cleaned contaminated wounds of not over eight hours' duration, never in wounds with established infection.
8. Reduction of fractures and dislocations, and retention in corrected position by traction or splinting in the position of function (position of grasp with wrist in dorsiflexion).
9. Application of protective dressing, fingers separated by gauze and hand immobilized to such extent as may be necessary to permit healing, in the position of function (never in the flat position).
10. Administration of antibiotics and protective antitoxin as indicated.

D. After-treatment.

1. Elevation and rest of the hand.
2. Noninterference with initial dressing for a sufficient time to permit healing, unless evidences of suppuration develop.
3. Restoration of skin coverage of denuded areas at earliest possible time. Partial thickness skin grafting is a simple and valuable means of promoting early healing.
4. Early restoration of function for nonaffected parts of the hand by directed active motion to the fullest extent that will not jeopardize healing of repaired structures.
5. Restoration of function in affected parts of the hand by directed active motion as early as is consistent with full healing and preservation of the repair of damaged structures.

Condensed from a statement prepared by the American Society for Surgery of the Hand, October, 1948.



Benjamin Rush: A Book Review

JONATHAN FORMAN, M. D.

BORN at Byberry, Pennsylvania, on January 4, 1746, Benjamin Rush lost his father in 1751. At thirteen years of age he entered the College of New Jersey at Princeton and was graduated with degree of Bachelor of Arts some fifteen months later.

In the autumn of 1760, he was apprenticed to Dr. John Redman. In August, 1766, he entered the University of Edinburgh and was graduated with the degree of Doctor of Medicine in June, 1768. He spent the next year visiting clinics in London and Paris. He entered the practice of medicine in Philadelphia. Dr. Rush was promptly elected professor of chemistry at the College of Philadelphia and in 1775, he was elected to the Continental Congress.

Dr. Rush went out with the Philadelphia Militia and was in the second battle of Trenton. He was promoted to Physician General, Middle Department of the Continental Army in April, 1777.

After the Revolutionary War, he returned to his teaching and practice. In the summer of 1800, Dr. Benjamin Rush began the composition of a document intended for his own private satisfaction and for the edification of his family. These papers, his "Travels Through Life," together with his "Commonplace Book for 1789-1813," have been edited by George W. Corner and are now printed in full for the first time from the original manuscripts in possession of the American Philosophical Society and the Library Company of Philadelphia *(The American Philosophical Society, Princeton University Press,* $6.00).

Looking back over his fifty-five years of active and exciting life, he recalled many great national events that he had seen and had taken part in, many actions of his own that he wished his sons and daughters to remember with pride, and not a few that he felt he must explain and justify.

"Travels Through Life"—The nine surviving manuscript notebooks containing the text have been transcribed without the omission of any words that the author intended to stand. Then follows his "Commonplace Book" which he kept from 1789-1813.

Rush lived in a period of transition from medieval to modern conceptions of body functions and disease. For this reason he got caught with concepts of fevers and their management which are often confused with the Brunonian Systems, but which were in fact quite different. Since he thought there was only one cause for fever. he insisted that there was only one kind of treatment. As Shryock has pointed out, born a few years sooner his friends and followers could have, and no doubt would have, made a Cult of his teaching on the age-old formula, "One Cause, One Cure, One Master."

Not only was Rush a great physician but he was a great citizen. He busied himself with ideas of government. Of this, he says:

"But I did not content myself by merely attacking old errors and prejudices from the press. I assisted in the institution of societies to carry them into effect. I was likewise for a while an active member of several societies whose objectives were altogether of a humane nature. They were the Society for the Gradual Abolition of Slavery, the Prison and the Humane Societies. I likewise assisted in forming the constitution of the College of Physicians, and was for a while a punctual member of it.

"I was often asked how I found time to do my business, compose lectures, answer letters, write for the press, and attend so many different societies."

In modern times, we physicians for the most part, have not taken an interest in social, intellectual, and civic life of our communities. We have been content to give up all reading and study, relying upon the spoon feeding which we are furnished by means of our hospital staff

meetings and the refresher courses that our medical societies provide. Our social contracts consist mostly of attendance at the luncheons of some Service Club. This has identified us with Industry, and puts the A. M. A. in the same class with N. M. A. in the minds of the average American workingman and farmer.

Your reviewer ascribes this to bad working habits engendered by our days in medical school and internship and residencies. Benjamin Rush's explanation is still good advice for every physician. He said:

"1. I never went out of my house in a morning before 9, 1/2 9, and sometimes 10 o'clock except when called by a sudden indisposition, or by a consultation at an earlier hour. By this means, I received all new applications so as to arrange them with business of the morning.

"2. I lost no time in my own house. The scrap of time which interposed between the hour I returned from visiting my patients and the times of eating, I spent in light reading or answering letters, or such process of business as required but little abstraction of mind. The evenings from 7, 8, or 9 o'clock, when not engaged in business or company, were always spent in study, sometimes in the same room with my wife and children, but latterly in a room appropriated to my use. I seldom left it 'till 11 or 12 o'clock at night.

"3. After 1789, I rarely dined or spent an evening out of my own house.

"4. I derived rest from fatigue in reading by writing, and from writing by reading, so as to require no other relaxation of body or mind for many hours. I likewise varied my studies, by which means no one of them ever palled, and I think I preserved my mind in a more pointed state by this practice to every study. I learned it from Ruisseau's history of his life.

"5. By visiting my patients in a carriage, I lost but little time out of doors. I was carried to them with quickness, and was less liable to interruptions and delays in the streets than when I visited them on foot.

"6. As I advanced in years I became more frugal of my time. To a young lady who was misspending her time, I once said I would willingly give a dollar, were it possible, for every hour she could not employ, and often I have, when thinking of the lost hours of my youth, wished for 'one ten thousandth of those hours that did no work' (Shakespeare's Henry IV) or that produced no fruit of study when I was a young man.

"7. I obviated the usual effects of hot weather in producing an inability to read, and thereby a waste of time, by spending the hot months in writing for the press. The greater the exertion necessary to compose than to read, always obviated sleepiness. It had the same effect upon me after dinner and late at night."

Those of us who are interested in agriculture will enjoy Rush's entries.

(Of the Chinese): It was reported to him that their vegetables have a vapid taste unlike ours. They manure their grounds with human manure, having no horses and few cattle to produce other manures . . . December (1801?): Mr. Knight informed me that his grandfather brought some apple and pear seeds to Pennsylvania with William Penn in 1682 and planted the same year at Abington. Twenty of those trees he sowed are still living. . . . Again December 1797: Mr. Wm. Russell told me Dr. Elisha Hall of Fredericktown kept two cows and two horses on the cullings of 1/4 of an acre of lucerne and 1/4 of an acre of clover during the summer. He cut the lucerne eight times in the course of one summer.

As one is reading his memoirs one is impressed with how poor our own lives have been. His diary shows a lively interest in almost every field in the natural life.

Something has happened to us physicians with our long drawn out disintegrated curriculum which leaves us with bad habits of study and personal cooperation, and interest in civic affairs. We have become mere believers and I am afraid society will not treat us as such.

Dr. Rush's manuscripts are full of references to the great men of his day, to agriculture abolition, old age, alcoholism, animals, banks and banking, battle field experiences, capital punishment, circulating libraries, congress, constitutional law, death and deathbed scenes and sayings, domestic difficulties, education, the Friends, immortality, longevity and survival, maternal impressions, medicine in the bible, midwives, overeating, physicians, prostitutes, suicides, unitarism, universalism, weather, wills and bequests, women, work and yellow fever.

Your reviewer would urge that you purchase a copy of this delightful autobiography and diary of this distinguished man and keep it handy for light reading and relaxation at noontime or before dinner. It will prove as stimulating as a cocktail and in no way injurious. There is much that you can learn from this wise old man.

Life Span

We hear much more about the problems of old age nowadays than we did twenty-five years ago, and it is proper that we should. In the Roman Empire the average life span was somewhere between 23 and 27 years. In 1900 it was 47; now it is 67.—Wingate M. Johnson, M. D., Winston-Salem, N. C.; Medical Annals of D. C., Vol. XVII, No. 12, December, 1948.

How To Pay A.M.A. Assessment . . .

Members Should Send Check for $25, Payable To Charles S. Nelson, Agent; Collections Will Be Transmitted to Chicago; Plans Progressing

BY now all members of the Ohio State Medical Association should have received a letter from Dr. A. A. Brindley, President, outlining the procedure established by The Council for the collection of the $25.00 American Medical Association assessment for financing nation-wide educational and public relations program.

THE PROCEDURE IS AS FOLLOWS: EACH MEMBER SHOULD MAKE HIS CHECK FOR $25.00 PAYABLE TO "CHARLES S. NELSON, AGENT" AND MAIL IT TO THE COLUMBUS OFFICE OF THE OHIO STATE MEDICAL ASSOCIATION IN THE YELLOW ENVELOPE WHICH ACCOMPANIED DR. BRINDLEY'S LETTER —NO POSTAGE REQUIRED. COLLECTIONS OF THE ASSESSMENT WILL BE FORWARDED PERIODICALLY TO THE CHICAGO OFFICE OF THE A. M. A. WITH THE NAMES OF MEMBERS PAYING THE ASSESSMENT.

Payment of the assessment should be made promptly so the A. M. A. can get going immediately on this nation-wide program which will include widespread dissemination of material exposing the fallacy of compulsory sickness insurance as proposed by President Truman; promotion and publicity on voluntary health insurance programs; enlargement of the Washington Office of the A. M. A.; and other activities to give the public accurate information on medical and health matters.

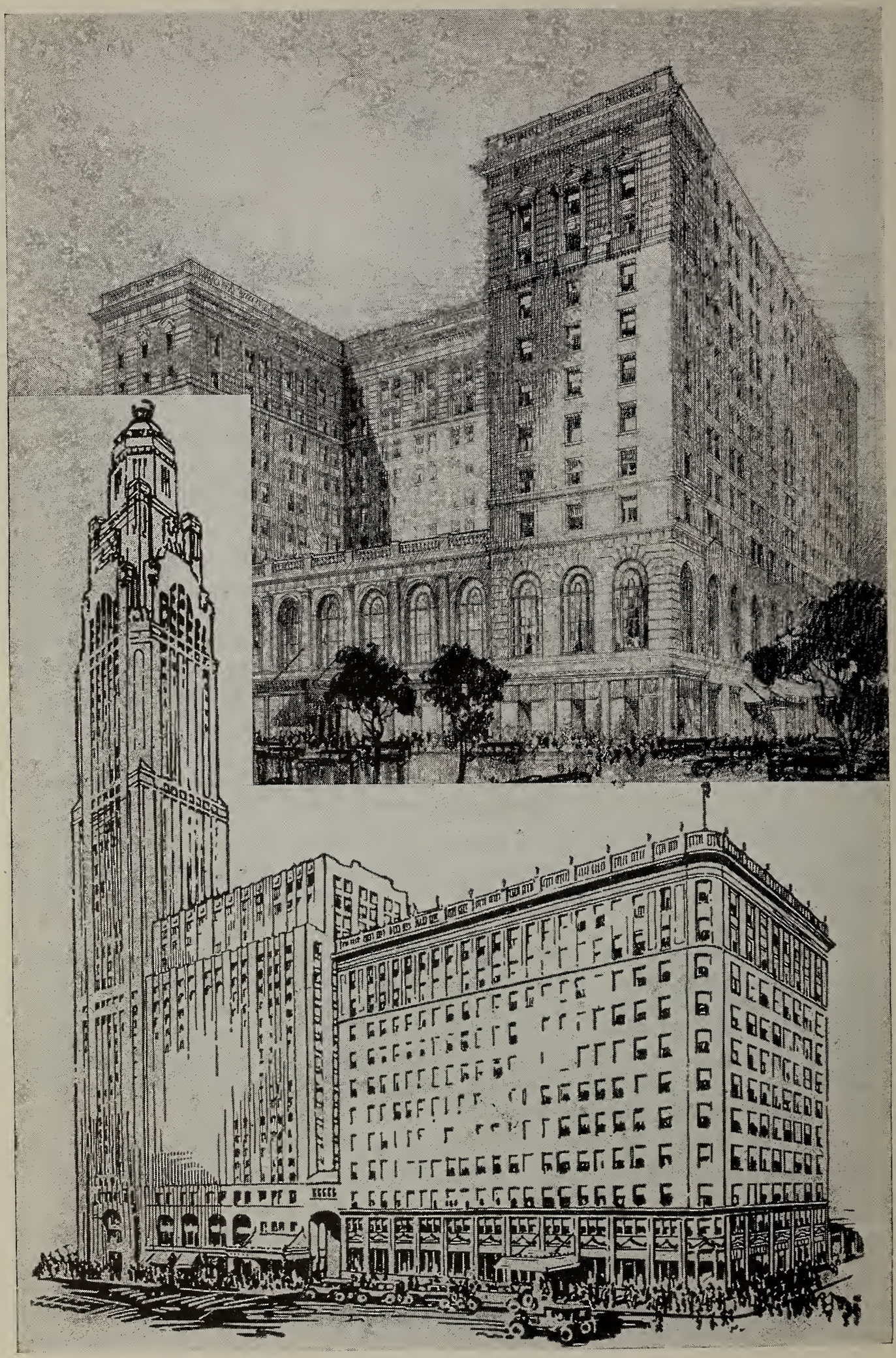
The 10-member Coordinating Committee which has been set up to govern the policies of the educational campaign met in Chicago the week-end of January 8-9 to lay the ground work for the program, in cooperation with the public relations firm of Whitacre & Baxter which will be in charge of technical details.

On February 12 secretaries and other representatives of State Medical Societies will meet in Chicago, if present plans materialize, to review the entire program and to work out plans for coordinating the activities of the state organizations with those of the A. M. A.

Plans have already been made by the Public Relations Department of the Ohio State Medical Association to cooperate in every possible way with the A. M. A. Until the A. M. A. program is ready to operate, the public relations activities of the Ohio State Medical Association will be carried on as usual—in fact stepped up to meet the needs and demands of Ohio physicians and the situation so far as Ohio is concerned. Material now on hand will be supplied Ohio physicians and the public, and new material, when available, will be distributed promptly.

Financing of the A. M. A. activities is the first important step to be accomplished. The additional steps are now in the making and will be put into execution as soon as feasible.

Submitting a check for $25.00 as outlined above is the first action which should be taken by each member. Later, he will be supplied with ammunition and instructions for firing it. This is not a job for a few physicians and a few public relations experts—it is a job for every member of the medical profession—every member of the Ohio State Medical Association so far as Ohio is concerned.



1949 Annual Meeting . . .

Scientific Sections, Instructional Courses, Entertainment, Exhibits, To Play Parts in Program Scheduled for Columbus, April 19, 20, 21, 22

ACTIVITIES of the **1949 Annual Meeting** of the **Ohio State Medical Association** will center in the two hotels shown on the opposite page—The **Neil House** and the **Deshler-Wallick Hotel** of Columbus. The dates: **Tuesday, April 19 through Friday noon, April 22. 1949.**

Scientific Sections in each of the following specialties will be held from 9 a. m. to 12 noon on the days indicated: **Tuesday**—Surgery, Anesthesiology, Eye-Ear-Nose-and-Throat; **Wednesday**—General Practice, Public Health and Preventive Medicine, Obstetrics and Gynecology; **Thursday**—Medicine, Nervous and Mental Diseases, Pediatrics.

INSTRUCTIONAL Courses, of which 18 are scheduled this year, will include subjects of practical, everyday interest to physicians. There will be six to choose from on three successive days. Subjects will be: **Tuesday**—"Present Day Management of Compound Fractures," "Suppurative Diseases of the Chest," "Spinal Anesthesia," "Management of Thermal Burns," "Management of Common Diseases of the Anus and Rectum," and "Management of Patients with Inoperable Neoplasms"; **Wednesday**—"Modern Methods of Therapy for Early Syphilis," "Accidents of Labor," "Diseases of the Gall Bladder," "Abdominal Emergencies of the Newborn," "Rheumatoid Arthritis," and "The Use of Antibiotics in the Field of Pediatrics"; **Thursday**—"Problem of Prematurity," "Evaluation and Management of Hypertension," "Cirrhosis of the Liver," "Dermatoses of Interest to the General Practitioner," "Management of the Unconscious Patient," and "Infant Feeding."

General Sessions—Six 30-minute lectures are scheduled in late afternoons. Nationally-known authorities in their respective fields will discuss subjects of current interest to all physicians.

Medical Topics of the Day—Wednesday afternoon from 3:35 to 5:15 will be devoted to five panel discussion groups. On Friday morning, six **Round Table Discussions** are scheduled from 9 a. m. to 12 noon.

Panels on Medical Economics—Thursday evening will be devoted to panel discussions on current medical economic problems faced daily by physicians.

SCIENTIFIC Exhibit—These exhibits of the latest developments in medical research always draw a large attendance. Each booth is presided over by research experts who will be happy to discuss their project with visiting physicians.

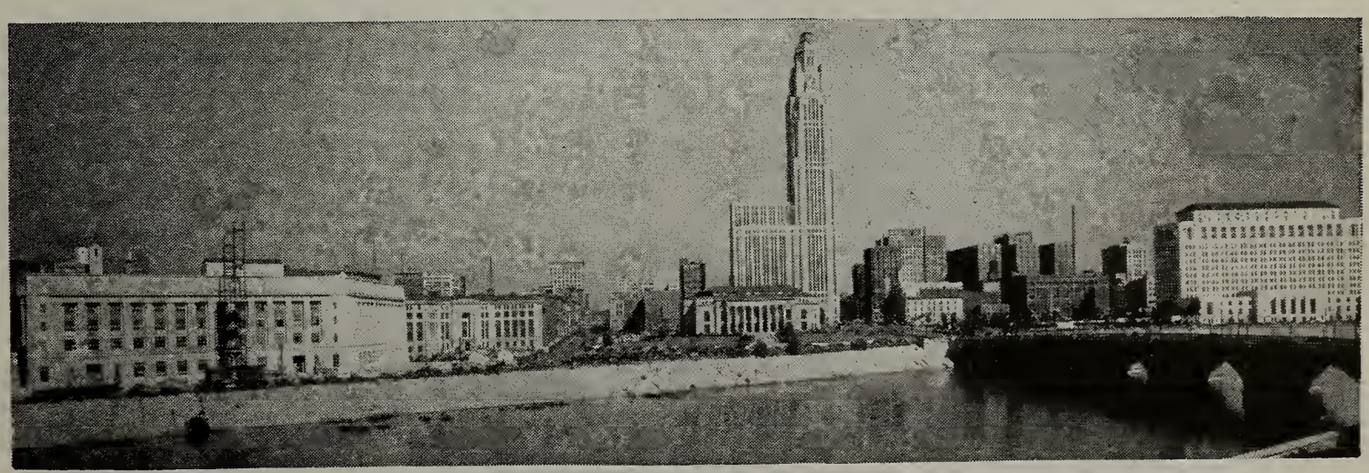
Technical Exhibits—Pharmaceutical and supply houses will display their supplies for scrutiny by physicians.

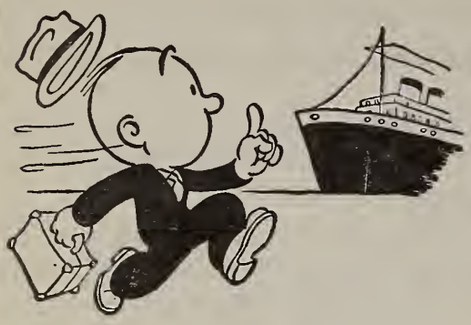
House of Delegates—The legislative body of the Association will meet twice to formulate policies and transact other annual business.

Annual Banquet—This is the highlight of social functions at the meeting. A program of music and entertainment will be followed by dancing. It will be on Wednesday evening, April 20.

Auxiliary—The Woman's Auxiliary will hold its annual meeting concurrently with the Association's meeting. The Auxiliary meeting will be at the Hotel Seneca.

A Complete Program of the 1949 Annual Meeting will appear in the March issue of *The Journal.*





Don't Miss the Boat

The "Boat" in This Instance Meaning

Hotel Reservations

for the

1949 ANNUAL MEETING

OHIO STATE MEDICAL ASSOCIATION

Columbus, Ohio — April 19 - 20 - 21 - 22

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
NEIL HOUSE, 35 So. High St. (Headquarters Hotel)	$4.00-7.00	$6.00-11.00	$8.00-11.00
DESHLER-WALLICK, Broad and High Sts.	$3.50-9.00	$6.00-14.00	$6.00-14.00
FT. HAYES, 31 W. Spring St.	$4.50-6.00	$6.50- 8.50	$7.00- 9.00
CHITTENDEN, High and Spring Sts.	$2.75-4.00	$5.00- 6.00	$7.00 and up
SENECA, 361 E. Broad St.	$3.50 and up	$5.00 and up	$7.00 and up
SOUTHERN, High and Main Sts.	$2.50 and up	$4.00 and up	$5.00 and up
VIRGINIA, Third and Gay Sts.	$3.00-4.00	$4.50- 5.50	$6.00- 7.00
BROAD-LINCOLN, 631 E. Broad St.	$3.00 and up	$5.00 and up	$7.00 and up

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager_____Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 19, 20, 21, 22, 1949, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price:_____

☐ Twin Bed Room with bath ☐ Suite

Arriving April_____at_____A.M._____P.M.

PLEASE VERIFY MY RESERVATION.

Name_____

Address_____

_____

Compulsory Medical Insurance . . .

Major Insurance Company Executive Discusses Question From Common Sense Viewpoint; Points Out Gross Inadequacies of Proposed Plans

"SHOULD We Adopt Compulsory Medical Care Insurance?" R. A. Hohaus, actuary, Metropolitan Life Insurance Company, asks and then answers this rather controversial question in the December issue of *American Economic Security*, a periodical containing information and opinion on social security, published by the United States Chamber of Commerce.

The editors of the magazine supplemented the article with their own comments, as follows:

"What might the national community reasonably expect from any governmental project of compulsory medical care insurance? In his thoughtful and dispassionate article . . . R. A. Hohaus suggests seven criteria which such a project surely ought to meet. Here they are; they are worth remembering:

1. Adequate medical care and facilities for all.
2. Free choice of doctor and patient.
3. Simple, decentralized administration with maximum local autonomy.
4. Method of compensation determined by those rendering the service.
5. Cost to the insured independent of the services he may receive.
6. Quality of medical care maintained and improved.
7. Total cost reasonable in comparison with amounts now spent.

"No bill for compulsory medical care insurance introduced as yet in Congress would accomplish the seven simple points listed above. Perhaps, as the author suggests, it is impossible for such a bill to be devised. Until it is, however, the proponents of compulsion might seek to perfect their blueprints instead of seeking authority to undertake so far-reaching and questionable a project." The text of the article is printed below.

* * *

Proposals for extension of our present social insurance system to medical care insurance have been the subject of much debate in reecnt years. Considerable confusion still remains, however, despite all the discussion that has taken place, and even some of the most fundamental questions remain unanswered.

There is still disagreement (a) as to the need for compulsion in the field of health services for the individual, (b) as to what aspects, if any, of health service plans should be sponsored by government and at what level—Federal, state, or local, (c) as to how the administration of plans should be allocated among the various levels of government, and (d) as to whether the role of a government agency should be to pay benefits, to render service, or to assist individuals in creating organizations for themselves.

The questions posed are not simply the pros and cons of broadening our social insurance system to include medical care insurance. Neither social insurance, as we now know it, nor the situation that medical care insurance seeks to meet, is in any sense static. A number of signs indicate that, irrespective of our decision as to any such broadening, the next few years will see major developments in the health service field. The chief needs would seem to be (a) to determine and clarify the significant issues, with a clearing away of irrelevancies, (b) to develop further the many types of attack on health problems, and (c) to make a careful appraisal of results.

One of the chief obstacles is a tendency to oversimplify the issues involved—a tendency to think in terms of catch phrases, to substitute epithets for thoughts, to feel that one needs only to take a position for or against a particular bill. It is nothing new that discussions in this field tend to be highly partisan, more often heated than temperate, more controversial than philosophic. Alternatives are presented as involving mutually exclusive choices—such as compulsion vs. voluntary action, over-all planning vs. individual initiative, Federal vs. state or local control, or cash benefits vs. service benefits. But the choices are by no means so simple or clear-cut.

COMPULSION VS. VOLUNTARY ACTION

Either compulsion or voluntary action can involve us in absurdity if pushed to extremes. While a degree of compulsion in the medical care field, as in other fields, may at times be desirable to conserve the real freedom of the majority—quarantine in case of smallpox, for example—

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compulsion should be so limited as to avoid undermining our traditional democracy, the keystone of which is individual responsibility for one's own welfare. Legal compulsion leaves no room for the legitimate exercise of strong-mindedness or even obstinacy—a crippling loss for an individualistic society. But freedom of action must be guided by a measure of restraint. Otherwise it degenerates into license, and so defeats its own end.

In our increasingly complex society both overall planning and individual initiative have a role to play for the best kind of progress. Government activities of the right sort in the field of health services can clear the ground for individual effort. Government and private enterprise need the stimulus of each other to bring out their full potentialities, and to prevent totalitarianism on the one hand or anarchism on the other.

But the individual has a basic responsibility for his own health; there must be full scope for the exercise of this responsibility. Individual interest—lay and professional—must be encouraged to the utmost. Yet, the ordinary citizen must have protection against ill-conceived plans which would do more harm than good, and against the charlatans who appear if no steps are taken to restrain them. Government must therefore make rules and prescribe safeguards to minimize the chances of failure.

Whether, in what circumstances, and to what extent government should attempt more than the role of an umpire is a more difficult problem, involving broad considerations of national policy. Issues in this field should be faced fairly and squarely, so that whatever steps are taken are illuminated by the full light of popular discussion and understanding. Important measures should not be "put over" by indirect approaches, political maneuvers, or flanking attacks.

In this country we have long had a measure of government activity in the field of health services. Much of what is now being done is generally accepted as a proper function of government. Hence, while the question too often debated appears to be whether the government should enter the field of health services, that is not the real issue. The question we should be studying is: In what health service areas should the government extend its activities, and in what areas should it discontinue or curtail present activities?

The evolutionary growth of government activity has been accompanied by growing voluntary action in developing new methods in medical economics. Both types of activity may be conceived as filling a vacuum created by the growing complexity and costs of modern medical care, a vacuum consisting of two needs: The need for the utmost economy and effectiveness in the distribution of services, and the need for methods of financing under which cost considerations will not operate as a barrier to needed service.

Recent years have seen great improvements in scientific knowledge and in facilities for health services. This in turn has led to re-examination of traditional methods of furnishing and financing medical care. As a result, experimentation in new methods has been greatly intensified, and recent progress has been greater than most of us would have dared forecast a few years ago.

The current situation is like a race between those who hold that only compulsory action, preferably by the Federal government, can adequately meet present needs, and those who maintain that expansion and improvement of voluntary methods is a much sounder approach —that increased compulsion would actually result in a decline in the quality of medical care. This state of affairs is deplorable as there are many questions needing calm, unbiased study if we are to continue to improve our methods of furnishing and financing medical care.

PROBLEMS OF MEDICAL CARE INSURANCE

These questions arise partly because of a fundamental difference between medical care insurance and other types of social insurance. In programs paying cash benefits the government's tasks are to set up eligibility requirements, to pay the benefits, and to raise the funds to meet their cost. No attempt is made to overrule the individual's judgment as to what he deems the necessities of life, to tell him how to spend his benefit dollar, or to provide necessities in kind.

But for medical care the problem is entirely different. Here it is not a case of paying cash amounts, but of having proper medical care available to an individual when he needs it. But who determines whether the individual needs care? If so, how much care? What kind? Who will make it available? How?

The answers will be quite different if there is no cost to the individual for the care he receives than if he is required to pay for treatment. Moreover, the answers will depend on the method of compensating the person rendering the service.

One method of paying the doctor is the traditional fee-for-service basis. Here it should be obvious that the volume of service—whether needed or not—rendered a given patient may vary greatly depending upon whether the patient or someone else pays the bill. Under this method the practitioner's total income is determined by the volume of service rendered, and not by the number of individuals served.

Another method is the capitation basis, used in the British health insurance system, under which the doctor receives a fixed monthly payment for each person on his list. His income

on account of a particular insured person is the same whether the insured receives no services whatever or whether extensive service is rendered. Under this method the practitioner's total income is based on the number of insured persons on his panel, rather than on the volume of service furnished.

The third method is the fixed-salary basis; here the amount of the salary may be determined in a variety of ways.

While one may find persuasive arguments for and against each method of payment, there has been a distressing lack of public discussion regarding them. As yet, there has been no proposal for the application of any of these methods to a government plan which includes adequate safeguards to assure a wider distribution of proper medical care on an efficient basis.

Another series of questions arises out of insistence that any plan should include free choice of doctor by patient and of patient by doctor. The statements of some advocates of government plans may readily lead us to assume that no difficulties will be encountered in retaining these freedoms. But here again we are faced with complexities in attempting to develop a workable and sound arrangement.

Related to the foregoing questions is another of importance: Should medical care on the traditional private basis be permitted to continue if a government plan is in operation?

At first glance one may think that these problems of how the doctor should be compensated, of freedom of choice, and of the status of private practice, are more or less administrative details. Quite the opposite, however, is the case. They are to a large extent the crux of the question of whether a government plan can successfully attain its objectives. Ample evidence of this statement may be found in the recent negotiations between Britain's doctors and the British officials, and in the reports which have appeared in this country concerning New Zealand's experiences.

The way these issues are resolved will largely determine how much regimentation of patients, physicians, and institutions will result, how much red tape and administrative expense there will be, and what the plan will cost. Even more important, the solutions reached will have considerable influence on the quality of the medical care which will be available. The complexities of these problems may be well summed up in the statement: "Sickness and the vagaries of human nature refuse to be neatly pigeonholed."

Some reference should be made here to another important problem of compulsory medical insurance: Can the concept of basic protection through social insurance, with supplementary protection available on a voluntary basis—a concept now widely accepted as appropriate in regard to old-age and survivors insurance—be applied to the field of medical care?

Medical care for the individual needing it should be continuous and uninterrupted, with the facilities for providing it closely integrated. "Supplementary protection," carrying on from where the compulsory provisions leave off, would often complicate matters and unnecessarily harass the patient by subjecting him to a switch from one system to another, perhaps just at the very time he most needs continuity of treatment. What the effect would be on the quality and effectiveness of medical care is a question for a physician to answer, but there is good reason for thinking that the answer would not be favorable. When a physician knows that his primary responsibility for a case is limited in time or extent, or shared with other physicians, should we expect his sense of responsibility, of independence, and of initiative in the case, or his personal relationship to the patient, to be keyed to as high a pitch as it otherwise might?

Space limitations do not permit comment on such questions as group practice and health centers, which should be considered in a comprehensive review of the subject. Perhaps, though, enough has been said to make it clear that in the field of government health services there is still much unexplored country to be charted, despite all the past discussions. Blindly following the precedents of our established social insurance plans, or of foreign systems, is certainly not the answer.

NEED TO AVOID ILL-CONSIDERED ACTION

The preceding comments probably evidence a lack of sympathy for at least some of the medical insurance proposals introduced in Congress and in some state legislatures. Efforts have been made to advance such bills by introducing an atmosphere of extreme urgency. While the importance of health problems must never be forgotten, there is the gravest kind of danger in dealing with them in such an atmosphere.

There are always those who feel that the present situation is so bad that anything will be an improvement, and who would hasten to make some change, however ill-conceived. Yet one does not have to condone the deficiencies of our present order to point out that irreparable damage can follow from ill-considered tampering with the complexly interrelated agencies that now operate in the medical care field, and which, if fairly appraised, have to be credited with doing a remarkably good job

Proponents of particular bills often counter criticism of their proposals with a challenge to make a constructive counter-proposal. The author must confess that he for one is not sufficiently ingenious to devise a compulsory medi-

cal care insurance plan to accomplish all of the following:

1. Adequate medical care and facilities for all.
2. Free choice of doctor and patient.
3. Simple, decentralized administration with maximum local autonomy.
4. Method of compensation determined by those rendering the service.
5. Cost to the insured independent of the services he may receive.
6. Quality of medical care maintained and improved.
7. Total cost reasonable in comparison with amounts now spent.

Perhaps the reason for this apparent inability to make a constructive counter-proposal is that it is not possible to devise a compulsory plan meeting all these specifications. Perhaps the most promising road to follow is the same one which has resulted in the development of a wide variety of plans and in the amazing progress of recent years. Often we center so much attention on our present status and on possible means of improving it that we overlook these remarkable developments.

SUCCESS OF VOLUNTARY EFFORTS

The substantial growth of voluntary health insurance plans, particularly against the costs of hospital care, surgery, and physicians' fees, is of comparatively recent origin, and within a comparatively few years tremendous gains have been registered. Protection against hospital expense was practically unknown 20 years ago; it is now provided for over 52 million individuals. The successful introduction of hospital expense insurance was followed by coverage for the cost of surgeons' fees, now afforded over 26 million individuals. Moreover, the last several years have seen considerable experimentation with insurance for various forms of non-surgical medical care by physicians, and already about nine million persons have this type of coverage.

All three coverages are still youngsters in the insurance field and continue to grow rapidly. Reference should also be made to the protection now in force against wage loss due to accidents and sickness. The latest estimates indicate that over 31 million wage-earners have some form of protection of this kind under a variety of arrangements such as group and individual insurance policies, mutual benefit association plans, sick-leave pay plans, and union plans. This volume of protection is striking, especially when viewed against the fact that the total employed population is about 60 million.

Recent studies have enabled those of us closest to the subject to get a quantitative view for the first time of the scope of voluntary effort. Much remains to be done in acquainting the public, particularly legislators and health workers, with the fine progress made. Much also remains to be done in appraising the effectiveness of these voluntary efforts, discovering the areas in which further growth may best occur, and generally in discovering how such efforts can be made more effective.

Also striking have been the developments of recent years in other health areas. The startling progress as reflected, for example, by improved mortality figures—underlines the view that the government, the medical profession, companies, organizations, and individuals interested in health should continue as in the past to experiment freely.

By this process we may arrive at a place 20 years from now far ahead of where we would be if we committed ourselves to some uniform plan. The latter course of action, even if it succeeded at first in raising present levels of availability, perhaps even of quality, in the medical field might thereafter be more likely to keep us frozen in a status quo than would otherwise be the case.

CONCLUSION

There are impressive reasons—both a priori and experimental—for believing that in the field of health services a uniform compulsory scheme is irreconcilable with our basic concepts of freedom and democracy. It seems beyond our present powers to devise any generally applicable scheme that can meet the requirements necessary to preserve these basic values. Thus, a more ardent pursuit of those paths that have made for progress during the last few decades would seem to be our most promising course.

Vacation Tour Planned

Ohio physicians and their families who are planning to attend the 1949 Annual Session of the American Medical Association in Atlantic City next June 6-10, may be interested in a vacation trip following the A. M. A. meeting. If so they may wish to take advantage of an all-expense airplane cruise from New York to Bermuda or a special train tour through Canada which are being arranged for A. M. A. visitors by the International Travel Service, Inc., Palmer House, Chicago. The reliability of the agency is vouched for by A. M. A. officials. Details may be obtained by writing directly to the agency at the Palmer House.

Polio Fellowships

A limited number of research fellowships are available in virology, orthopedic surgery, pediatrics, epidemiology and neurology under sponsorship of the National Foundation for Infantile Paralysis, Inc. Further information may be obtained by writing the Foundation at 120 Broadway, New York 5.

Federal Health-Medical Programs . . .

Two Committees of Hoover Commission Recommend Many Changes in Present U. S. Departments, Including Utilization of Physicians

A LARGE number of sweeping changes in the Federal government's health and medical programs were recommended to the Hoover Commission by one of its "task force" subsidiaries, the Voorhees Committee, whose job consisted of surveying the Federal government's activities in the health, medical and hospital fields as a whole.

Another sub-committee of the commission, the Eberstadt Committee, which surveyed the National Security Organization, recommended radical changes not only affecting the Army, Navy and Air Forces medical departments, but bearing directly on the Veterans Administration and the U. S. Public Health Service.

VOORHEES COMMITTEE

Recommendations of the Voorhees Committee included the following:

Establishment of a cabinet-status Federal department encompassing health, education and welfare activities, with a National Bureau of Health that would administer all general hospitals of the Army, Navy, Veterans Administration and the U. S. Public Health Service.

Transfer of all medical functions of the Veterans Administration, including outpatient services now performed at regional and branch offices, to the proposed National Bureau of Health.

Greater utilization of private and voluntary hospital facilities for care of veterans and others on a reimbursable basis.

VETERANS AID SCRUTINIZED

Action by Congress to decide to what extent medical and hospital services should be extended to veterans.

Appointment of a deputy to the Secretary of Defense who would supervise medical services in the armed forces.

Transfer of Food and Drug Administration to the National Bureau of Health's public health division.

Retention by the Children's Bureau of its present medical health and grant-in-aid activities.

Creation of a coordinating committee on nonmilitary medical research comprising representatives of the National Bureau of Health's research and training division, the Atomic Energy Commission and the Department of Agriculture. Also establishment of an Inter-Agency Committee on Medical Sciences, representing both military and nonmilitary branches of the Federal government, whose primary concern would be with appraisal and allocation of government support to non-Federal research institutions.

Transfer to the proposed research and training division of all operations now performed by the National Institutes of Health (research arm of the U. S. P. H. S.)

Establishment of a new Federal career medical service whose nucleus would be the present personnel of the Veterans Administration hospitals, the commissioned personnel of the U. S. P. H. S. and all medical professional personnel employed under Civil Service.

Institution by the U. S. Public Health Service of a study to determine financial needs of the nation's medical schools and recommend how they should be met, with aid given in such a way as to increase the output of trained personnel especially in areas where there are acute deficiencies.

Unification of medical supply procurement.

Over-all coordination of Federal organizations in the medical field by the Bureau of the Budget.

EBERSTADT COMMITTEE

Some of the major recommendations of the Eberstadt Committee were:

Establishment of a single Federal hospital system, which would administer all governmental hospitals—Army, Navy and Veterans Administration included—located within the continental limits.

Study of the feasibility of reducing the patient load of military hospitals by curtailment of services to dependents, the point being noted that 42 per cent of all beds in naval hospitals are occupied by nonservice patients.

That the armed forces strive for greater conservation of their medical man power and enhancement of its efficiency.

The report of the Eberstadt Committee included the following: Recommendation that a separate medical department be established to serve the U. S. Air Force; criticism of the recent Army order which subordinates the Surgeon General to the Director of Logistics; suggestion that the medical division of the National Security Resources Board coordinate the allocation of affiliated reserve medical units for duty in event of emergency; praise of the Office of Naval Research for its work in initiating and supervising medical and other types of scientific studies.

Commenting on its recommendation in regard to hospital services to military personnel dependents, the committee suggests that the solution might be found in provision of medical insurance with an increase in monetary allowances to provide for such a plan.

On the Firing Line . . .

Shots At Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"IF I am sick, I really want someone to look after me. If I am about to die, I want to make sure that I am given every chance the medical profession can offer me.

"I do not want someone, whose salary goes on whether I live or die, making a casual observation. I do not for a moment question the ethical attitudes of the medical profession either under socialized medicine or in private practice.

"But boy, oh boy, I sure do question human nature and am fearful of it. If you take the incentive of building a private practice or of sustaining a reputation away, I am afraid the socialized doctor is liable to relax and rest on his oars."—*Dann O. Taber in The Athens Messenger.*

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"They (Compulsory Health Insurance Plans) result in two sorts of medicine—good medicine for the well-to-do; and bad for the masses, at high cost to those who can least afford it." *Dorothy Thompson, in The Cleveland Plain Dealer.*

* * *

"If it is so difficult to pay once for medical care, what shall be said of the difficulty of paying twice—once in taxes, and a second time in order to have the kind of treatment one desires." —*A. J. Todd, Manager, Christian Science Committee on Publications, Washington, D. C.*

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"The essence of good doctoring was diagnosis, and diagnosis called for time and close-up with the patient, denied at the moment to thousands of practitioners."—*Lord Horder, London, England (Regarding the British Compulsory Health Insurance scheme).*

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"Virtually all medical insurance or social medicine programs are 'sold' on the basis that the patient can still choose his own doctor. The catch in this seems to come when a patient wants to change doctors. Such a contingency is provided for, of course. But anyone who has had experience with the 'paper work' involved in government processes realizes that a great measure of freedom to act goes out the window when it is necessary to fill out forms in quadruplicate and wait for 'official approval' before moves can be made."—*Mansfield News Journal.*

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"A doctor who didn't want to become socialized could work independently but might have hard sledding. His patients would be compelled to pay twice for the same service. While paying directly, they would be taxed for the socialized services they were foregoing."—*Massillon Evening Independent.*

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"It may not be long before the lawyers will find themselves shoulder to shoulder with the doctors in a fight against socialization. England, after several years of government medicine, now proposes to establish a form of government-supported legal service.

"The English plan is contained in a legal aid and advice bill, presented in November to Parliament by the Lord High Chancellor. It will probably be enacted by the Socialist majority without much delay."—*Raymond Moley, in The Columbus Dispatch.*

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"The subject of socialized medicine is not merely a matter of the rights of physicians; it goes much deeper than that. If the doctors of the country can be socialized, why not the lawyers, the teachers, the newspapermen, the farmers or labor? If medicine can be socialized, why not steel or bread? If the argument for socialism is good at all, it is good for everything."—*George E. Sokolsky, in The Columbus Dispatch.*

* * *

"As long as our economic thinking is so muddled, and we keep asking for handouts as members of pressure groups, we may go on backing into socialism without realizing how far we've gone. That would not mean a majority chose it. It would be just the line of least resistance for people who had the gimmes."—*Philip W. Porter, in The Cleveland Plain Dealer.*

* * *

"I do not have the time to point out all of the violations of insurance principles inherent in all the Government plans thus far advanced, and especially in the plan now being advocated

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by Federal Security Administrator Ewing. I shall speak of only two.

"First, the premiums to be collected from employer and employee bear no relationship to the risk involved. They are based upon the incomes of the insured rather than the amount of protection offered. In the second place, the premiums to be collected represent only a small part of the cost of the benefits to be distributed. The rest is to be paid from general taxes . . . this is not insurance . . . it is the purest kind of socialism."—*Dr. Paul R. Hawley, Blue Cross-Blue Shield Executive Officer.*

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"It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care."—*Report of The Brookings Institution on "The Issue of Compulsory Health Insurance,"* 1948.

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"The truth is that medical care is only one factor in our quest for health. And it's by no means the most important one. Good health depends on many things—healthy parents, a stable society, a satisfactory job, a happy family, education, nutrition, housing, sanitation, soap and water, accident prevention, good judgment, good luck, and avoiding bad medicine. To a great extent the doctor's role today remains what it was in Hippocrates' day—to comfort, reassure, and relieve the sick."—*Greer Williams in Better Homes and Gardens.*

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". . . A National Compulsory Health Law by contrast in its final evolution defeats and denies private initiative and throws instead the entire burden upon government. At the same time it will lower the standard of health care by its quantitative methods as European experience has convincingly demonstrated." —*The Most Reverend Karl J. Alter, D. D., Bishop of Toledo.*

* * *

"The dead hand of bureaucracy can destroy the wholesome flexibility of the voluntary hospitals which usually are controlled by a lay board familiar with local conditions and directed by a medical board of competent physicians and surgeons. The proof of the adequacy of our hospitals is that we have the largest plant in relationship to population and the best hospitals in all the world."—*George E. Sokolsky, in The Columbus Dispatch.*

". . . The trap was most cunningly baited in half a dozen different ways. Some of us were attracted by one illusory lure, others by another. More of us probably were moved by fear, fear for our children, our wives, and for ourselves. How many of us already wish that we might awake and find that it had all been a nightmare!" —*Excerpt from a letter of Dr. Donald M. O'Connor, Launceston, Cornwall, England, to The British Medical Journal.*

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". . . And to contend that a government-imposed health insurance program is 'the logical development of private insurance' is tantamount to arguing that a totalitarian state completely dominating all lines of industry is the logical outgrowth of democracy and free enterprise."—*The Hartford Courant.*

* * *

. . . "On the other side was a young housewife, married to a draftsman. 'I have the same doctor I had before, only now I'm under the NHS. When my little girl was sick I called him, and when he came he just said: "What's the matter?" as if he wanted to say: "What is it *this* time?"

'He was all right when he saw she was sick and needed him. But he prescribed some sulfa drug and he didn't come back or even telephone to find out how she was getting on. I suppose he is just too busy. But he took a lot better care of us before the NHS." *Comment on British National Health Service in Newsweek Magazine.*

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Federal encroachment on the practice of private medicine "would do more to advance statism against democracy than anything that the Russians or the Communists are doing."—*General Dwight D. Eisenhower.*

* * *

"We know beyond question that when the American people understand the issues and learn the facts about compulsory health insurance, they will reject it. But our primary job is not so much to prove our case *against* socialized medicine, as to make our voluntary program work so well that all our fellow-citizens will join us in defending it."—*J. Howard Hornberger, M. D., president, The Medical Society of New Jersey.*

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"In a few words, the executive branch of the government is now back to the basic principle of the New Deal—the policy accurately described as "tax and tax, spend and spend, elect and elect." This is the trade-mark of a Socialist-Labor government, such as that which is steadily reducing the British people to universal poverty." —*Farm Journal.*

Rules Governing Laboratories . . .

Health Department Issues Stricter Regulations Especially in Regard To Inspections and Qualifications of Directors and Technologists

REVISED rules governing the approval of laboratories for the performance of serologic tests for syphilis as a part of premarital and prenatal examinations required by Ohio laws, have been issued by State Director of Health John D. Porterfield, effective January 1, 1949.

In a statement which accompanied the rules, Dr. Porterfield said:

"It has been decided that a laboratory which has completed the 1946 and 1947 evaluation tests with an approvable score and which has the same director as at the time of such approval will continue to receive approval so long as it continues to make a passing score on the annual evaluation test. This clause will apply to those laboratories whose directors do not qualify under the 1949 rules.

"Any laboratory which has failed to pass an evaluation test or which so fails in a future evaluation test will no longer be eligible for the benefits of this clause.

"Laboratories which have been approved during 1946 and 1947, but which have changed or change directors, will be eligible for approval only under the conditions of the 1949 rules."

The 1949 rules, which will apply to all laboratories seeking approval for the first time, to those which have changed or change directors, and to those which fail to pass an evaluation test, forcing it to make re-application at a later date, contain more rigid requirements in some respects than those previously in effect.

The revisions apply primarily to the qualifications of the director (Rule 2); qualifications of technologists (Rule 3); and the inspection of laboratories (Rule 4).

As revised and now applicable, the 1949 rules are as follows:

1. **General Provisions**—a. No laboratory will be granted approval until it has been in operation for a period of at least one year. In the event that an approved laboratory changes directorship, the laboratory must submit a new application for approval.

b. The laboratory must examine not less than a total of one hundred (100) serologic specimens monthly.

c. The director must agree to abide by any and all rules promulgated by the Ohio Department of Health.

2. **The Director**—a. The director shall be considered the "person in charge" of an approved laboratory He must hold a degree from a college or university recognized by the North Central Association of Colleges and Secondary Schools, with a major in bacteriology and serology or biology or chemistry.

b. He must have had a minimum of three years actual work in the performance of clinical laboratory examinations, one year of which must have been in serology; one year of postgraduate work in biological sciences may be substituted for one year of laboratory experience.

c. He must devote not less than three-fourths (75 per cent) of his time to laboratory activities, and must assume responsibility for the accuracy of the serodiagnostic tests for syphilis done by the laboratory.

d. The director of the laboratory, for the purposes of the premarital and prenatal laws, shall be the same director as supervises all activities of the laboratory. No individual shall serve as director of approved laboratories in more than one geographic area, so that direct and frequent supervision of serologic practices can be assured.

3. **Technologists**—The person or persons actually performing the tests must be registered technologists or the practical equivalent in terms of knowledge and ability in the performance of these tests. Names and qualifications of technologists must be filed with the Ohio Department of Health.

4. **Inspection**—a. Each applying laboratory must pass an annual inspection made by a representative of the Division of Laboratories of the Ohio Department of Health. This inspection will cover such prerequisites as adequate material, apparatus, equipment, space and location of the laboratory.

b. A demonstration of the performance of the procedures under consideration will be expected of technologists at the time of inspection.

5. **Serologic Evaluation**—a. Each applying laboratory must participate in the serologic evaluation survey conducted by the Division of Laboratories of the Ohio Department of Health.

b. Full approval for performance of the test evaluated will be granted to those laboratories attaining a passing score in the evaluation survey. (Passing score: 99 per cent specificity-agreement with negative sera; 90 per cent sensitivity-agreement with positive sera.)

6. **Specimens**—All approved laboratories must accept, without discrimination, blood specimens

submitted in accordance with the requirements of the prenatal and premarital laws (G. C. 1243-9 and 11188, respectively), by any physician licensed to practice medicine and surgery in the State of Ohio. (Opinions Attorney General, 1946, p. 669.)

7. **Forms To Be Used**—a. Only the premarital examination form prescribed and furnished by the Ohio Department of Health, as required by Section 11188, of the General Code, shall be used by approved laboratories and by physicians in making the statements to be filed in the probate court by applicants for marriage. A premarital examination form shall not be sent to the physician submitting the blood specimen until the serologic test has been made and the laboratory statement completed and signed by the person in charge of the approved laboratory. Probate courts are prohibited from accepting any other form.

b. The serologic report forms prescribed and furnished by the Ohio Department of Health shall be used by all approved laboratories in reporting to the Ohio Department of Health the results of premarital and prenatal serologic tests.

c. When completing the laboratory statement in the premarital examination form, the person in charge of the approved laboratory shall give, in detail, the full name, address, age and color of the applicant for marriage and the name and address of the physician who submitted the blood specimen for serologic test. Deficiency in information shall be secured from the physician submitting the specimen before reporting the result of the test or completing the laboratory statement.

8. **Serologic Tests**—a. Serologic tests for syphilis approved by the Ohio Department of Health, for the purposes of the prenatal and premarital laws (G. C. 1243-9 and 11188, respectively), are those known as Eagle, Kahn, Kline, Kolmer and Mazzini.

b. Serologic tests must be carried out according to the current recommended procedure of the author of the test. (Latest recommendation of the author will be provided annually by the Ohio Department of Health Laboratory.)

c. When a serologic test for syphilis gives a "positive" or "doubtful" result, the person in charge of the laboratory shall request the examining physician to submit another blood specimen, and shall hold the original report until the specimen is rechecked or a repeat specimen is tested or refused, but not longer than two (2) weeks. If recheck is made, both reports, suitably attached, must then be reported to the physician submitting the blood specimens.

9. **Outfits for Sending Specimens**—Each approved laboratory shall provide for its use suitable outfits for receiving blood specimens from physicians. The information card accompanying the outfit shall call attention to the necessity of giving full information regarding the specimen. When such outfits are to be sent by mail, they shall meet the requirements of the Postal Laws and Regulations. Physicians who use an Ohio Department of Health mailing container for sending a blood specimen to an approved laboratory must be notified by the person in charge of the laboratory that such use is prohibited.

10. **Submission of Reports**—The copy of each report to a physician giving the result of a prenatal or premarital serologic test, which the law (G.C. 1243-8 and 11188, respectively) requires shall be sent to the Ohio Department of Health, shall be forwarded to the Department at the close of each day's work or as soon thereafter as possible. Positive and doubtful reports shall be held until the provisions of paragraph 8-c are complied with. Before mailing these reports, the person in charge of the laboratory shall see that all items are properly entered and the report signed.

11. **Policy**—The policies of the approved laboratory shall comply and conform with the intent, purposes and provisions of the Ohio premarital and prenatal laws. The activities of approved laboratories shall be conducted in an ethical manner.

12. **Records**—Records shall be kept of all serodiagnostic tests for syphilis performed in the laboratory for a period of not less than one (1) year, and such records shall be open to inspection by a representative of the Ohio Department of Health.

13. **Advertising**—a. Any advertising relative to serodiagnostic tests for syphilis shall be restricted to professional channels. Advertising shall not contain the words "approved," "certified," or other words to the same effect, except in relation to serologic tests for syphilis, to which approval by the Ohio Department of Health is legally restricted.

b. The laboratory must submit, to the Director of Health, samples of letterheads, cards, or any literature, present or future, which contain reference to the approved serologic service.

14. **Revocation of Approval**—The approval of a laboratory for the performance of premarital and prenatal tests for syphilis may be revoked at any time for failure to comply with the provisions of the premarital and prenatal laws or the rules promulgated by the Ohio Department of Health.

15. **Premarital Tests for Other States**—No Ohio approved laboratory shall make a serologic test for an applicant for marriage in another state unless such test is authorized by the premarital law or regulations of that state.

Sensenich Urges 9,000 Young Doctors To Volunteer

In a letter mailed recently to 9,000 physicians under 26 years of age, Dr. R. L. Sensenich, South Bend, Ind., president of the American Medical Association, strongly urged them to volunteer for military duty.

"The United States must depend on the young physicians who were educated during the war and who have had little or no active military duty to volunteer in this time of the nation's need," Dr. Sensenich said. "Thousands of older physicians served voluntarily during the war and the responsibility now rests upon the young men to continue the medical profession's record of service."

Excerpts of Dr. Sensenich's letter, prepared in cooperation with the Council on National Emergency Medical Service of the A. M. A. follow:

"The Selective Service Act of 1948 provides that men between the ages of 19 and 25 inclusive who did not serve on active duty for more than 90 days during World War II, and who are not otherwise entitled to deferment, are subject to the draft. This provision includes physicians as well as other men.

"Many physicians under 26 years of age with less than 90 days active duty in World War II are considering the decision they must make. This letter is sent in the hope that the information and advice offered will help you to make a wise decision.

"The present world situation is such that military preparedness is an absolute necessity. The current expansion of the armed forces together with a proportionate increase in their medical components is therefore inevitable.

"The medical departments of the Armed Forces are making a sincere and vigorous effort on their part to achieve these aims.

"The medical service corps has been created and expanded relieving doctors of many administrative duties previously required.

"An additional stipend of $100 a month is being paid medical officers who volunteer for active duty prior to being called for induction.

"Training opportunities and career guidance plans have been developed.

"Intensified research programs have been activated.

"Numerous other changes have been effected which make service in the medical corps of the Armed Forces a valuable professional experience.

"The acceptance of a reserve commission is evidence of willingness to serve and may be presented to the local board in support of your request for occupational deferment until the completion of your current year of internship or residency. Should you volunteer prior to being called for induction, you may make arrangements with military services to postpone your active duty for a similar period.

"Every effort is being made by the military services, and by the medical profession through its representatives at the highest planning levels to assure: (1) That the minimum number of physicians will be called to active duty; and (2) that professional training will be utilized and advanced to the maximum extent. . . ."

COMPULSORY SICKNESS INSURANCE BILL DROPPED INTO HOPPER

As this issue of *The Journal* went to press, here was the situation on the Congressional front:

Senators Murray, Wagner, and McGrath introduced Senate Bill 5, the controversial compulsory sickness insurance measure in line with President Truman's recommendations. It is reported to be a replica of the old W-M-D bills.

Similar bills were introduced in the House by Representative Dingell and by Representative Celler, H R. 345 and H. R. 783, respectively.

S. 5 was referred to the Senate Labor and Public Welfare Committee; H. R. 345 to the House Ways and Means Committee, and H. R. 783 to the House Committee on Interstate and Foreign Commerce, of which Congressman Crosser, Cleveland, is chairman.

A bill, S. 132, to provide larger grants-in-aid for the development, maintenance and extension of local public health units, was introduced by Senator Chapman, Kentucky.

Several bills, H. R. 184 and H. R 782, to make the Federal Security Agency a Department of Health, Welfare and Education, with cabinet status, were introduced, as well as a number of measures to provide more funds under the Hill-Burton Hospital Construction Act and to liberalize the formula by which such funds are distributed to the states and local communities. Bills to create a National Science Foundation also were presented.

Analyses of these measures, with policy comments, will be published in *The Journal* at an early date.

Otolaryngology

The sixth annual postgraduate course in Otolaryngology will be given at St. Luke's Hospital in Cleveland from March 28 to April 2 inclusive. This course is sponsored by the Department of Otolaryngology of St. Luke's and the Department of Anatomy of Western Reserve University School of Medicine. Excellent material will be provided for supervised cadaver surgery.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

FINANCES A REAL CHALLENGE TO NEW ADMINISTRATION

Strange times, these times, aren't they?

President Truman in his message to the new Congress advocates increases in Federal taxes—income and payroll taxes—to finance a bloated budget, weighed down with added expenditures for social welfare activities, including compulsory sickness insurance.

Ohio's incoming Governor, Frank J. Lausche, in his inaugural address takes a strong position against the imposition of new Ohio taxes. At the same time, Governor Lausche advocates some liberalization of programs to protect the people of Ohio against the hazards of unemployment, disability and old age, asks for a slum elimination program, and endorses a welfare and hospital building program within the limits of the present state income.

It is indeed a study in contrasts. On the one hand, we find a dictatorial Federal government which is bankrupt asking for more revenues and more power and authority to run the daily lives of everyone. On the other, we find a solvent state hoping to live within its present income and adopting a go-slow policy on additional expenditures and new activities.

Obviously, at first glance, Ohio taxpayers will applaud the stand taken by Governor Lausche. Nobody likes taxes—old or new. However, the situation is not quite so simple. Let's look at the picture in its entirety.

If Truman gets his way, all taxpayers are going to pay more taxes—taxes to Uncle Sam. Congress is going to be told by Truman (he's already spoken in part) that the Federal government is going to have to do more and more because the states can't or won't. If Congress votes the legislation he is asking for, the Federal government will take over more and more of the functions and responsibilities which belong to the states—Ohio—activities which should be operated and financed by the states—Ohio.

If that's what the people of Ohio want, let them remain silent and forever hold their peace. If they want the Federal government to encroach still further into Ohio's affairs, then there is no reason for revamping the present activities and budget of the State of Ohio.

On the other hand, if the people of Ohio want to see the State of Ohio operate and finance its own programs of public service; if they don't relish having Ohio's government agencies dependent to a large extent on Federal handouts and taking orders from Washington arm-chair experts, then they should speak up loudly, promptly, and often. They should let Governor Lausche and the State Legislature know that they don't like the present state of affairs, especially the situations in the health and welfare departments. They should insist that exceptionally careful study be given to the state's financial program for the present biennium.

If the new state administration can meet its obligations, which includes proper financing of essential state agencies, without imposing new taxes, everyone will be happy. On the other hand, it should not be blinded by the slogan "no new taxes" to the point that it fails to realize that a dangerous situation, such as described above, exists and fails to thoroughly analyze the financial requirements of all the necessary state agencies—not just a few of them.

Before the Governor and the Legislature can decide definitely that the state can get along without new taxes, they are going to have to adopt a more equitable method of dividing up the state's revenues than methods used in the past. The old method has forced some essential agencies—the health department, for example,—to depend on the Federal government for substantial amounts of money for operating expenses. Specifically, the health department has had to look to Uncle Sam for almost three-fourths of the money it requires for current activities. This is not a healthy condition, in our opinion. New taxes or no new taxes, this situation should be remedied.

We are certain that Governor Lausche and the General Assembly want to do what they think is best for the whole State of Ohio. We believe they will want to put Ohio's public health program on a sounder basis. The job can't be done without rather substantial readjustments in the present method of financing the state health department. The department needs more state money so it will not have to depend on the Federal government for huge grants-in-aid. More adequate financial support for the department will have to come either from new tax money or through a more equitable allocation of the funds produced from present taxes. That's the problem confronting the Governor and the new Legislature.

Frankly, if it becomes necessary to impose new Ohio taxes to maintain the dignity and integrity of the State of Ohio, to keep Federal meddlers out of Ohio's affairs, and to provide all of the essential state agencies with a decent budget,

financed from state funds, there are plenty of Ohioans who won't object too seriously, if at all, in our opinion.

Before Ohio taxpayers can tell their Congressmen to vote against new Federal taxes, they are going to have to make a real effort to have Ohio put its own house in order on the matter of financing its own departments.

TWO EXCELLENT APPOINTMENTS

Governor Lausche used excellent judgment, in our opinion, on appointments to two cabinet posts which are of special interest to the medical profession.

As director of the Ohio Department of Public Welfare, Governor Lausche named Judge John H. Lamneck, Tuscarawas County, who has had broad experience in welfare activities and possesses the know-how to manage this complicated and vital activity of the state government.

Maj. Gen. Leo. M. Kreber, Columbus, commanding general of the 37th Division, Ohio National Guard, was appointed Adjutant General. An able Army officer, as well as one of Columbus' outstanding business men, General Kreber will, among other things, have the assignment of setting up a civilian defense program for Ohio, to be used in event of another national emergency.

The medical profession congratulates the Governor on these appointments and extends to each appointee its cooperation and assistance on all matters involving medical activities of their respective branches of the state government.

REMINDER TO PHYSICIANS ON TAX LIABILITIES

Recently an Ohio physician who employs several girls in his office was assessed penalties for failure to comply with the provisions of the Ohio Unemployment Compensation Act. He admitted ignorance of the law which of course was not a valid defense.

If this can happen to one physician, it might happen to others, despite the fact that a complete round-up on taxation matters is published at least once a year in *The Journal*. Therefore, the following reminders are offered to physicians who have office help:

The Old Age Benefits Tax under the Federal Social Security Act is payable by every physician who employs one or more persons in his office. The employer must contribute one per cent on the first $3,000 of each employee's wage, and a like amount is deducted from the wages of each employee. The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed in the office of the District Collector of Internal Revenue.

Under the Ohio Unemployment Compensation Law, physicians who employ three or more persons must file an "Employer's Contribution, Form UCO-2-e, Report," and Form BUC-475X report of individual worker's wages, quarterly, with the Ohio Bureau of Unemployment Compensation, Columbus. The tax, which must accompany the return, amounts to 2.7 per cent of the quarterly payroll, unless qualified for a modified rating, known as the experience rating.

Employers of eight or more persons in 20 weeks during a calendar year, under the Federal Unemployment Excise Tax, must have filed with the District Collector of Internal Revenue on Form 940, prior to January 31 of each year, a report of wages paid during the preceding year.

The tax is three per cent, less a credit amounting to 90 per cent of the Federal tax if the employer of eight or more has paid his contributions in full to the Ohio Bureau of Unemployment Compensation. In effect any such employer whose state tax liability is paid in full, need pay a rate of only three-tenths of one per cent under the Federal tax act.

Also, physicians having three or more employees must comply with the Ohio Workmen's Compensation Act by filing reports and paying premiums.

Detailed information on the above matters should be obtained from the governmental agencies involved. Tax counsel should be used if complications arise.

THERE IS NO "BREAK" BETWEEN BLUE CROSS AND BLUE SHIELD

Those who would like to put the medical profession behind the eight-ball have taken great delight in interpreting the refusal of the House of Delegates of the American Medical Association to endorse the organization of a national Blue Cross-Blue Shield national hospital and medical insurance organization as "an open break" between hospitals and the medical profession—between Blue Cross and Blue Shield.

Those who are informed about the action of the A. M. A. know that such a charge is unfounded. There was, and has been, no "break." There is a difference of opinion as to how national enrollment in prepaid plans should be obtained and on technical matters in the establishment of an agency to do that job. At the same time, Blue Cross and Blue Shield have common objectives and they are working together in many, many ways to achieve their goals. This cooperation should, and will continue, in our opinion.

Evidence of the above statement is substantiated in the following editorial published in the January, 1949, issue of *Hospitals*, official publication of the American Hospital Association—comment which knocks into a cocked hat the false charges of those who are following the slogan "divide and conquer" in efforts to poison the mind of the public against the present

voluntary hospital system and the private practice of medicine:

"A resolution adopted by the Board of Trustees on December 11 clears away the first big hurdle to unlimited expansion on voluntary prepaid health insurance. This resolution authorizes the formation of Blue Cross Health Service, Inc., and Blue Cross Association.

"Blue Cross Health Service, Inc., is to be an insurance corporation through which large-scale employers can sign a single contract and in this way extend Blue Cross protection to their employees anywhere in the United States.

"As originally conceived, the contract would cover both hospitalization insurance through Blue Cross and medical care insurance through Blue Shield. A month ago, however, the House of Delegates of the American Medical Association declined to approve participation by the Blue Shield plans. As explained in the news section of this journal, Blue Cross will now proceed alone and in such a way that Blue Shield may join later.

"In reporting this development, at least one newspaper has interpreted it as 'an open break' between the American Hospital Association and the American Medical Association. There is no basis for such an implication.

"When the quality of medical care is threatened by a federal compulsory health insurance program, physicians and hospitals have nowhere to stand but together. The American Hospital Association believes it necessary, first, to expand voluntary prepayment facilities as far and as fast as possible The American Medical Association sees public education against the evils of government medicine as the first step.

"Both approaches are needed, and certainly each complements the other. When physicians were ready two years ago to promote voluntary prepayment on an individual area basis, they found that hospitals already had prepared the ground. If and when physicians are ready to join in a **national** program, again they may expect to find the sod broken and the seed planted."

EVERYTHING BUT "CHAINS" COULD BE LOST

"The most important thing which is occurring in this country is use of the power of government to expropriate and liquidate the middle class," says *Railway Age* in an editorial in a recent issue.

An even swift glance at the programs which have been laid before the present Congress for action would seem to confirm this assertion. Beating down the great middle class which is the backbone of our economic system appears to be the objective, directly or indirectly, of those in the political saddle.

Those who have the opportunity to discuss these current happenings in public or private gatherings will be remiss in their responsibilities if they fail to emphasize and re-emphasize this point.

This concluding paragraph of *Railway Age's* comments packs a real wallop and should be repeated again and again:

"About a century ago Marx and Engels concluded the Communist Manifesto with the words: 'Workers of the world, arise! You have nothing to lose but your chains.' This might now be appropriately paraphrased to read: 'Middle class of America, arise! You will soon have lost everything but your chains.' "

CAN'T HAVE THEIR CAKE AND EAT IT

How're you going to have your cake and eat it? This age-old dilemma apparently confronts the leadership of the Cooperative Health Federation of America with regard to compulsory health insurance.

A letter to F. S. A. Administrator Ewing, written November 24 by Jerry Voorhis, the Federation's executive secretary, hints that the co-op group desires "to support" national health insurance legislation, then proceeds to make a case for voluntary prepayment plans. (December issue of Cooperative Health Federation of America Information Letter.)

For example, the Federation wants "adequate provisions to safeguard and encourage the exercise of the opportunity of groups of people to form voluntary prepayment, consumer-controlled organizations to service their own needs for medical care."

Mr. Voorhis reminds the Administrator that "health insurance will provide certain amounts of money for the people to use in paying for health care. But in and of itself, it will not assure that people will receive either comprehensive care, the advantages of group practice and preventive medicine, or a better distribution of medical facilities or professional services."

Dealing with the matter of health plans sponsored by labor unions, Voorhis told the Administrator that: "it would be a mistake we are certain—and we are confident you will agree—to remove incentive for the development of such plans or to render their continued operation unlikely."

Mr. Voorhis offers this very pertinent observation: "But we recognize also there is one very real possible danger which must be avoided. That is the danger that the passage of such an act may lead to a belief on the part of the people that they have no further responsibility for the solution of their health problems. From every point of view such a result would be bad. For many and great problems will still remain —problems which can be solved only by the action of voluntary groups of people."

Commenting on the problems of rural America, he points out that this is "the very group

which will be hardest to cover with health insurance," and adds: "Unless, therefore, our proposals are taken into account in the legislation, there is a very real chance that the benefits to rural people will be all too small. This could well cause members of Congress from rural areas to decide not to support the legislation at all."

The Federation would accomplish all this by amending the proposal to permit voluntary plans to contract with the government for payments to cover their members.

Mr. Voorhis, in our opinion, is not naive enough to think that any politically-controlled plan administration is going to let the voluntary plans have a look-in. Also, he knows that you can't make a purse out of a sow's ear. He and his group are going to have to play take-it-or-leave-it. If they are sincerely interested in seeing voluntary plans of whatever kind succeed, they are going to have to stand in opposition to the Ewing proposal on the basis of principle. Tinkering with it on details and technics won't cure it.

SPEAKING ABOUT ASSESSMENTS

Woodruff Randolph, president of the International Typographical Union, has advised the union's 37,000 members that it may be necessary to extend the weekly four and one-half per cent strike assessment levied against them, according to *The Labor Union*. The article points out that the weekly four and one-half per cent assessment voted in February, 1947, plus a one-half per cent strike assessment in effect prior to February, 1947, had brought into the union an estimated $1,000,000 a month.

The next time the boys in the scrub room or at the corner drug store begin to chew the fat about the A. M. A. $25.00 assessment (less than 50 cents per week, as we figure it) advise them what Mr. Randolph and his boys are doing to back up their point of view.

RURAL OHIO LOSES A REAL FRIEND

Rural Ohio has lost a real friend in the death of Dr. George H. Lasher, Meigs County veterinarian, who had served as chairman of the Ohio Rural Health Council since its inception, seven years ago.

Moreover, the medical profession of Ohio has lost a valuable co-worker in its efforts to guide and direct the expansion of health services for the farm people of the state.

Largely through the efforts of Dr. Lasher, the Council has enjoyed tremendous growth in the past five years and has developed a constructive program for the improvement of health among farm folks.

Dr. Lasher died in the harness. He had gone to Columbus from his farm near Rutland to preside over a meeting of the executive committee of the Council, and was staying over to attend the annual meeting of the Ohio State Veterinary Medical Association when death came.

He was chairman of the executive committee of the Ohio Forestry Association, and was interested in conservation activities, having dedicated his property as a tree farm last October.

It will not be easy to fill the vacancy created through the untimely passing of Dr. Laser.

PHYSICIANS' GUIDANCE NEEDED IN HEART CAMPAIGN

The week of February 14-21 has been designated as National Heart Week by the American Heart Association. Here in Ohio a state-wide organization has been created to carry on an intensified public education and fund raising campaign that week and throughout most of February. County units are being organized and physicians are being requested to cooperate in organizing the campaign and by speaking on heart disease before civic groups and clubs.

It is suggested that all county medical societies participate in this educational program. Groups of this kind need—and welcome—the advice and guidance of the medical profession. Unless they are properly guided by physicians, they can easily make mistakes which would be detrimental to both the public and the profession.

A GOOD MEDICAL SOCIETY IS ONE WHICH DOES BOTH

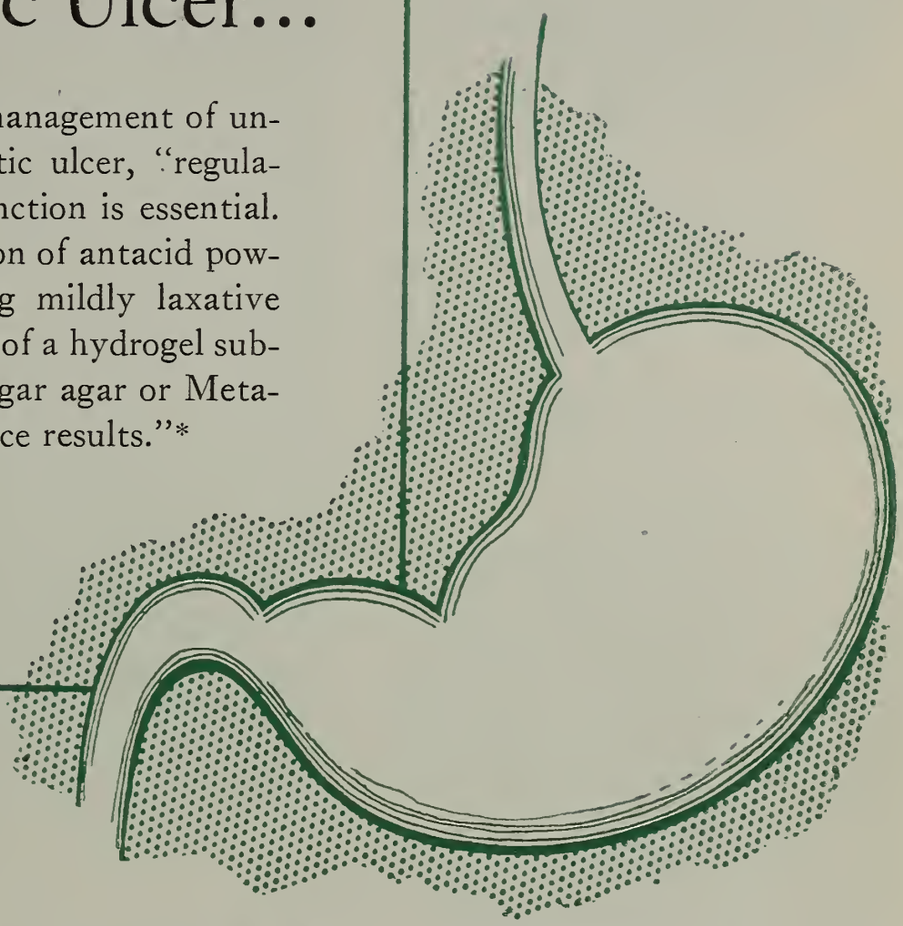
An excellent biography of medical societies in Cleveland, especially of what is now known as the Academy of Medicine of Cleveland and Cuyahoga County, written by Dr. Clyde L. Cummer, a former president of the Cleveland Academy and the Ohio State Medical Association, was published recently in the *Ohio State Archaeological and Historical Society Quarterly.*

Commenting on the article, N. R. Howard, editor of *The Cleveland News*, points out that "few Clevelanders realize how much this healthful city owes its Academy of Medicine" and draws the moral "that doctors do most for us as individuals and citizens when free of outside —including political—pressure."

Therein lie several lessons for every local medical society. First, do things which will win the esteem and confidence of the people of the community. Secondly, let the public know what it is doing. Those local medical societies which fail to measure up on the first point cannot justify their existence. Those which fail to follow the second suggestion are short sighted.

Bowel Regulation in Peptic Ulcer...

In the medical management of uncomplicated peptic ulcer, "regulation of bowel function is essential. . . . A combination of antacid powders . . . having mildly laxative effects or the use of a hydrogel substance, such as agar agar or Metamucil, will produce results."*



By furnishing a water-retaining, gelatinous residue in the large bowel, Metamucil acts gently without irritation to promote smooth, normal evacuation.

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is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Gerendasy, J.: Modern Treatment of Peptic Ulcer, J. M. Soc. New Jersey *43*:84 (March) 1946.

Annual Reports Show Extensive Work Done by State Medical Board

Annual reports made to the State Medical Board by Inspectors Frank A. Dorsey and Laurence A. Dietrich, show 197 investigations with a total of 1,500 calls during 1948, according to Dr. H. M. Platter, secretary.

Investigations were made in 65 counties of the state and comprise the investigation of licensed as well as unlicensed practitioners. Thirty-six cases were filed in court—27 persons being convicted and three acquitted. Three persons whose cases were filed in 1947 were convicted in 1948.

Cases pending from former years and disposed of in 1948 were: A. G. Hulbert, Toledo, found guilty, fined $75 and costs; G. R. Ensminger, Elyria, found guilty, fined $500 and $300; Annis Shade, Bowling Green, fined $25; Wm. Henning, Columbus, fined $250; Keith Good, Columbus, fined $250; Mrs. Wm. Henning, Columbus, fined $50; F. J. Boyer, Cleveland, fined $100; W. R. King, Toledo, fined $400, $100 suspended; John P. O'Neil, Toledo, fined $25; Dorothy C. Thompson, Toledo, fined $50.

Cases filed in 1948 and disposed of: Lewis E. Puaria, Toledo, fined $75 and costs; Arthur Nagede, Cleveland, fined $100 and costs; Theo. G. Steinle, Cincinnati, fined $25 and costs; David Shaw, Cincinnati, fined $50 and costs; A. A. Marohn, Cincinnati, fined $50 and costs; Frank H. Burch, Cincinnati, fined $100 and costs, sentenced to thirty days in the workhouse, suspended on good behavior; Salvadore T. Rizzo, Cincinnati, found guilty and placed on probation for six months; Herbert R. Reaver, fined $500 and costs and six months in the workhouse (case appealed); Walter Wenger, Akron, fined $100 and costs (case appealed); Mayer L. Nearing, Cleveland, fined $25 and costs (case appealed).

Fred John Moran, Toledo, fined $200 and costs, $100 suspended on good behavior; H. L. Kislig, New Philadelphia, fined $25; A. F. Schott, Dover, fined $25 and costs, suspended on good behavior; F. R. Mowry, Bellefontaine, acquitted by jury; Geo. W. Harmon, Bellefontaine, acquitted by jury; Jos. DeBortoli, Bellefontaine, found guilty by jury, fined $100 and costs (case appealed); A. D. Gutilla, Columbus, fined $100 and costs (case appealed); Walter Moser, Warren, acquitted by jury; Eliott Lewis Wright, Toledo, fined $100 and costs, suspended on good behavior, placed on probation; A. R. Hartzog, Toledo, fined $150 and costs (case appealed).

Raymond L. Smith, Akron, fined $500 and costs; Wm. J. Wilson, Toledo, indicted by the Grand Jury, case pending trial; Harry A. Ziegler, Toledo, indicted by the Grand Jury, case pending trial; Edw. J. Schreiber, Toledo, indicted by Grand Jury, case pending trial; Wm. A. Pierchola, Toledo, indicted by Grand Jury, case pending trial; Wm. M. Binder, Toledo, indicted by Grand Jury, case pending trial; Ralph A. Carter, Toledo, indicted by Grand Jury, case pending trial; Carroll McGhee, Toledo, fined $50 and costs, $25 suspended, placed on probation; John O. Hozier, Warren, case pending trial; Donald L. Dennis, Cincinnati, fined $25 and costs.

Mary Titus, Akron, fined $50 and costs; Wilbur J. Rinehart, Toledo, fined $50 and costs; Chas. E. Ishler, Toledo, fined $100 and costs, served out part of fine in jail; Emil Esselstrom, Akron, fined $100 and costs, $75 suspended; Amo Esselstrom, Akron, fined $100 and costs, $75 suspended; Howard Thos. Flynn, Akron, case pending trial; Edwin Musich, Painesville, fined $100 and costs, $75 suspended; Michael Breauski. Painesville, fined $100 and costs, $75 suspended; Lena Manns, Toledo, found guilty, sentence not imposed, pending motion for new trial; Florence Mills, Port Clinton, fined $500 and $250; Wm. M. Bullock, Jr., Canfield, case pending trial.

Cases filed awaiting trial: Hector R. Harter, Dayton, still pending in Municipal Court; Ruth M. Mack, Dayton, still pending in Municipal Court.

Eighty-one complaints were investigated where prosecutions were not instituted. Sixteen practitioners were investigated and their cases reported to the Board for consideration. In addition to fines assessed, 404 days in the workhouse were assessed against offenders. Nine cases filed during 1948 are pending.

VACANCIES FOR PHYSICIANS

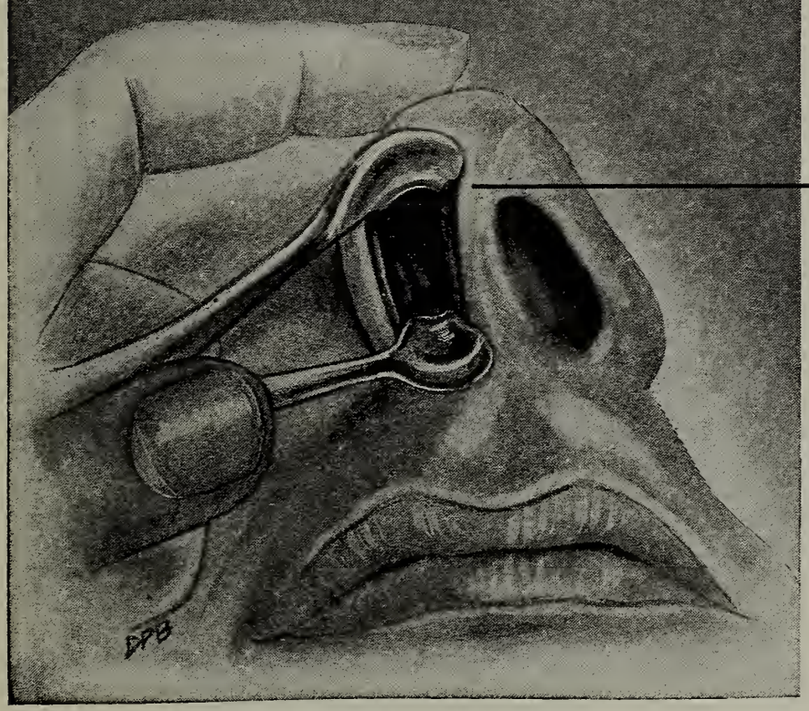
There are several vacancies on the medical staff of the State Industrial Commission. Physicians interested should apply personally or by letter to R. M. Andre, M. D., Supervisor, Medical Section, State Industrial Commission, State Office Building, Columbus, Ohio.

Correction

In the December issue of *The Journal* it was stated that the Ohio State Medical Board revoked the license of Julius Rabb, M. D., Cleveland, after he was found guilty on a charge of criminal abortion. This statement was incorrect. The license of Dr. Rabb was revoked after he was found guilty of Federal income tax evasion as the result of evidence divulged in a suit charging him with criminal abortion. The case for alleged criminal abortion was nol-prossed and Dr. Rabb was not tried on that charge.

Estimates indicate that there are about 2,000 physicians in displaced-person camps in Europe.

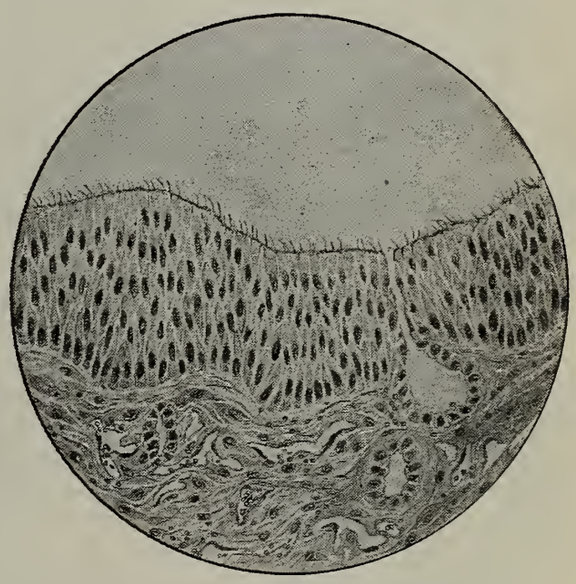
promotes aeration . . . free drainage in colds . . . sinusitis





Nasal membrane showing increased leukocytes with denudation of cilia.

Normal appearing nasal epithelium.



Nasal engorgement and hypersecretion accompanying the common cold and sinusitis are quickly relieved by the vasoconstrictive action of

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The decongestive action of several drops in each nostril usually extends over two to four hours. The effect is undiminished after repeated use.

Relatively nonirritating . . . Virtually no central stimulation.

Supplied in ¼% solution (plain and aromatic), 1 oz. bottles. Also 1% solution (when greater concentration is required), 1 oz. bottles, and ½% water soluble jelly, ⅝ oz. tubes.

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Do You Know? . . .

Dr. George E. Rockwell, Milford, president of the American College of Allergists, was a guest speaker at the annual meeting of the Southeastern Allergy Association, Jan. 22-23, at Durham, N. C.

* * *

Massachusetts General Hospital, Boston, is planning the construction of a $2,750,000 research building to permit consolidation and expansion of its research program.

* * *

The American Nurses' Association is making a complete inventory of all professional registered nurses in the United States. Request for the inventory came from the National Security Resources Board, which is charged with formulating for the President of the United States plans and policies concerning industrial and civilian mobilization of the nation's man power in the event of war.

* * *

The House of Delegates of the Connecticut State Medical Society recently approved the establishment of a prepayment surgical care plan to be operated in cooperation with the Connecticut Blue Cross organization.

* * *

The State Headquarters Office of the Ohio State Medical Association has received hundreds of requests for copies of "Date With the Doctor: Some Helpful Hints for His Receptionist," following favorable comment on the booklet in *The Journal of the American Medical Association* and *PR News*, nationally circulated public relations news letter.

* * *

Only those accustomed to the freedom of the press can realize the utter darkness in which Germans were kept during Hitler's regime, said Dr. Elsa Klein of Chillicothe on her recent return after a month's visit to Germany. Dr. Klein who left Germany in 1930 to become an American citizen reported that the Germans need enlightenment as well as food.

* * *

"News and Pictures Showing Recent Progress in the Field of Medicine," was the streamer head on a page of features in the *Cleveland Plain Dealer* on January 4. Most of the articles and pictures shown were from syndicated feature services. Among illustrations was that of an X-ray microscope developed by Dr. Paul H. Kirkpatrick, Stanford University.

* * *

Dr. T. H. Sutherland, Marion, in December, attended the presentation ceremonies for the Collier Trophy in the office of the President, Washington, D. C. Dr. Sutherland is secretary of the Aero Medical Association, an organization of flight surgeons.

* * *

The Business and Professional Women's Club of Newark early in January announced the choice of Dr. Geraldine Crocker of Granville as "Woman of the Week."

* * *

Dr. Hugh Scott Cumming, surgeon general of the U. S. Public Health Service from 1920 to 1936, died in Washington on December 20 at the age of 79.

* * *

The United States Public Health Service has allocated $115,590 in Federal funds to the Ohio Department of Health for development of the state cancer control program during 1949.

* * *

Rear Admiral Joel T. Boone, MC, USN, Washington, D. C., is the new president of the Association of Military Surgeons of the United States. On duty with the 6th Marines as a division surgeon in World War I, Admiral Boone was awarded the Congressional Medal of Honor; the Silver Star, with five Oak Leaf clusters; the Distinguished Service Cross and many other decorations. He was White House physician during the Harding, Coolidge and Hoover administrations.

* * *

Only four persons cancelled subscriptions to the *Saturday Evening Post* as a result of its July 24, 1948, article blasting antivivisectionists.

* * *

Transfer of the Bureau of Mental Health from the Department of Welfare to the Department of Health was recommended by Governor Duff of Pennsylvania in a recent address to the legislature of that state.

* * *

Plans are being developed by officials of the American Dental Association for a nation-wide information program concerning dentistry's opposition to a national system of compulsory health insurance for the dental profession.

* * *

The Bureau of Health Education of the American Medical Association has produced a new series of electrical radio transcriptions, entitled "Guardians of Your Health." The series consists of 13 programs each timed to 14 minutes, 30 seconds. It is available on a free loan basis to county medical societies for use on local radio stations. Complete information may be obtained by addressing the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago 10.

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In Memoriam . . .

Howard H. Beane, M. D., Cleveland; Cleveland Medical College, Homeopathic, 1898; aged 74; died December 9; former member of the Ohio State Medical Association and the American Medical Association through 1940. Dr. Beane spent most of his years of practice in Youngstown and went to Cleveland in 1939. His fraternal interests included membership in the Masonic Lodge and the Youngstown Optimist Club. Surviving are his widow, one son and a brother.

William Truman Bennie, M. D., Cleveland; Indiana University School of Medicine, 1927; aged 45; died December 31; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Bennie practiced medicine in Cleveland from 1929. During the war he served with the Army Medical Corps and attained the rank of major. Surviving are his widow and a son.

Elmer E. Clark, M. D., Oakley, Ill., Barnes Medical College, St. Louis, 1898; aged 78; died December 8 as the result of an automobile accident. Dr. Clark was a native of Gallia County where he visited often.

Wilbur Saunders Crowell, M. D., Cleveland; Western Reserve University School of Medicine, 1899; aged 76; died December 9; former member of the Ohio State Medical Association and the American Medical Association through 1935. Dr. Crowell practiced industrial medicine in Cleveland for more than 30 years, until his retirement in 1936. Surviving are his widow, a son and a daughter.

Emory Francis Davis, M. D., Springfield; Medical College of Ohio, Cincinnati, 1897; aged 78; died December 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Davis practiced his profession in Springfield for more than 50 years and was active until a few days before his death. He was a past-president of the Clark County Medical Society and last year was the society's nominee for the A. M. A.'s Gold Medal Award. He was a member of the Methodist Church and of several Masonic Orders. Surviving are his widow and a son.

Sidney Weiss Durschlag, M. D., Cleveland; Ohio State University College of Medicine, 1931; aged 42; died December 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Durschlag practiced medicine in Cleveland since the completion of his education. During the war he served as a Captain in the Army Medical Corps. Surviving are two sisters.

Merit Donald Haag, M. D., Toledo; University of Michigan Medical School, 1918; aged 56; died January 6 in Florida; member of the Ohio State Medical Association and a Fellow of the American Medical Association; past-president of the Academy of Medicine of Toledo and Lucas County; diplomate of the American Board of Obstetrics and Gynecology; fellow of the American College of Surgeons, and member of the Central Association of Obstetrics and Gynecologists; secretary in 1945 and chairman in 1946 of the Section on Obstetrics and Gynecology, Ohio State Medical Association. Dr. Haag had been associated for more than 25 years with the Toledo Hospital where he was director of the department of obstetrics and gynecology. Surviving are his widow, a son and a daughter.

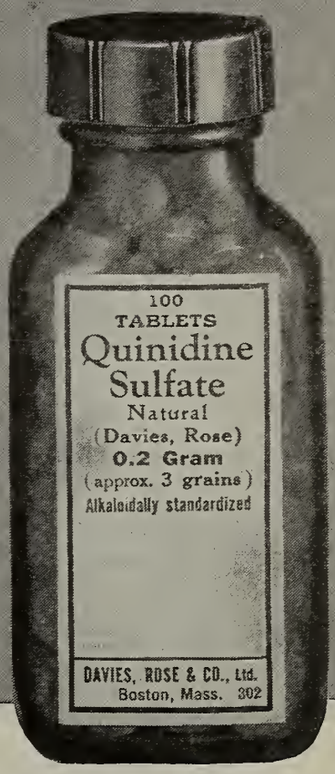
Virginia Borum Hickerson, M. D., Cincinnati; University of Virginia Department of Medicine, 1926; aged 57; died December 25; member of the Ohio State Medical Association and the American Medical Association; certified by the National Board of Medical Examiners in 1928. Since 1942, Dr. Hickerson had been pediatrics coordinator for Hamilton County, in charge of control of tuberculosis in children. Surviving are her husband, Dr. William D. Hickerson, a daughter, two brothers and three sisters.

Leonard Kawasaki, M. D., Cincinnati; University of Cincinnati College of Medicine, 1929; aged 45; died December 28; member of the Ohio State Medical Association and the American Medical Association; Dr. Kawasaki, a native of Hawaii, practiced in Cincinnati since the completion of his education. He served during the war in the Army Medical Corps and later became a member of the American Legion. Surviving are his widow, his mother, two brothers including Dr. Isaac Kawasaki of Honolulu, and four sisters.

Charles Edward Kiely, M. D., Cincinnati; University of Cincinnati College of Medicine, 1913; aged 61; died December 30; member of the Ohio State Medical Association; Fellow of the American Medical Association; president of Academy of Medicine of Cincinnati in 1940, its secretary in 1925 and delegate, 1927 and 1929-35; member of the American Psychiatric Association and the Central Neuropsychiatric Association. Dr. Kiely was assistant professor of psychiatry at the University of Cincinnati College of Medicine and was consultant in psychiatry at several Cincinnati hospitals. He also was active in legal phases of psychiatry. During World War I he served in the Army Medical Corps and later was active in the reserves. Surviving are his widow, two sons,

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Dr. Charles E. Kiely, Jr., Iowa City, Iowa, and Brian Kiely, a medical student, and a sister.

Merton Ray Kittridge, M. D., Bryan; Ohio State University College of Medicine, 1916; aged 62; died January 5; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1946; president of the Williams County Medical Society, 1927, secretary, 1925-1926, and vice-president, 1929, 1937, 1939-40 and 1942-45. Dr. Kittridge practiced medicine in Bryan for approximately 30 years prior to his retirement during 1946. Surviving are two daughters, a son and a sister.

Henry Edward Kock, M. D., Cincinnati; Cincinnati College of Medicine and Surgery, 1902; aged 71. Dr. Kock had been a teacher in Woodward High School until his retirement in 1944.

William Frederick Koerner, M. D., Cleveland; Long Island College of Medicine, 1890; aged 80; died December 28. After practicing in Brooklyn for 38 years, Dr. Koerner retired and made his home in Cleveland.

Leonard Frank Lauf, M. D., Columbus; Jefferson Medical College, Philadelphia, 1907; aged 65; died December 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Lauf practiced in Columbus for approximately 41 years. He was a member of the Catholic Church. Surviving are his widow and two sisters.

Emma O. Jones McCormick, M. D., Columbus; Northwestern University Women's Medical School, Chicago, 1890; aged 89; died January 9. She is survived by one sister.

Robert Gordon McMurray, M. D., Marion; Ohio State University College of Medicine, 1927; aged 49; died January 6; former member of the Ohio State Medical Association and the American Medical Association through 1944; secretary of the Marion County Academy of Medicine, 1930, 1937-38. Surviving are a daughter and a sister.

Eliza Johnson Merrick, M. D., Syracuse, N. Y.; Cleveland University of Medicine and Surgery, 1884; aged 91; died December 14. Dr. Merrick had practiced in Cleveland before her retirement.

Charles Edward Murray, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1903; aged 72; died January 1. Dr. Murray practiced medicine in Cincinnati for approximately 45 years. He was a member of the Catholic Church. Surviving are his widow, three daughters, two sons, three sisters and two brothers.

Paul Julius Opperman, M. D., Cleveland; University of Wooster Medical Department, Cleveland, 1895; aged 76; died December 17; former member of the Ohio State Medical Association and the American Medical Association through 1946. Dr. Opperman practiced in Cleveland from 1914 until his retirement in 1940. He was a member of the Presbyterian Church. Surviving are his widow, a son and a brother.

William Daniel Schafer, M. D., Portsmouth; University of Illinois College of Medicine, 1910; aged 62; died December 23; former member of the Ohio State Medical Association and the American Medical Association through 1934. Dr. Schafer in addition to practicing medicine in the vicinity was health commissioner for New Boston for a number of years. During World War I he served with the Army Medical Corps.

Harry M. Schuffell, M. D., Canton; Western Reserve University School of Medicine, 1893; aged 82; died December 23 in Florida; member of the Ohio State Medical Association; Fellow of the American Medical Association; president of the Stark County Medical Society in 1931; diplomate of the American Board of Surgery; fellow of the American College of Surgeons. Dr. Schuffell practiced medicine in Canton for 55 years. In addition to his professional work, he was active in fraternal and other organizations of the community, among which were several Masonic Orders, the Odd Fellows, the Rotary Club and the Congress Lake Club. His widow survives.

Jean David Spaid, M. D., Dayton; Ohio State University College of Medicine, 1922; aged 54; died December 14; former member of the Ohio State Medical Association and Fellow of the American Medical Association through 1947; diplomate of the American Board of Anesthesiology; member of the American Society of Anesthestists, Inc.; second vice-president of the Montgomery County Medical Society in 1936. Dr. Spaid retired from active practice several years ago because of ill health. He was active in many organizations, among which were several Masonic Orders, the American Legion, and the Dayton Country Club. His widow survives.

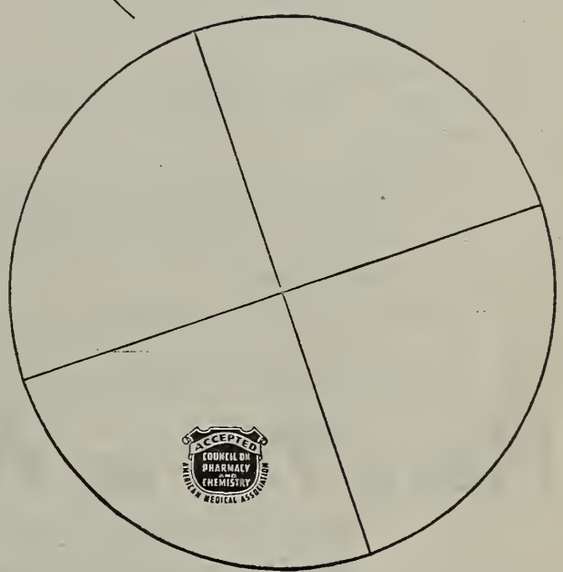
Granville B. Trout, M. D., Zanesville; Starling Medical College, Columbus, 1892; aged 87; died December 15; former member of the Ohio State Medical Association and the American Medical Association through 1944; president of the Muskingum County Medical Society in 1926, vice-president, 1920-23 and delegate in 1922. Dr. Trout began practice in Zanesville in 1919 and during his time there served a four-year term as county coroner. He was a member of the Lutheran Church and several Masonic Orders. Dr. Trout was a recent recipient of the Muskingum County Medical Society distinguished service certificate. Surviving are his widow, three daughters and a sister.



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Northern Tri-State To Hold Program In Fort Wayne, April 12

The Northern Tri-State Post-Graduate Medical Association will hold a program at the Chamber of Commerce Auditorium, Fort Wayne, Ind., on Tuesday, April 12, with registration beginning at 8:30 a. m. The program is as follows:

Welcome Address, Dr. Orville J. Miller, president, Allen County Medical Society, Fort Wayne.

Address, Dr. Don F. Cameron, Fort Wayne, president of the association.

"Surgical Emergencies of the New-Born," Dr. Clifford D. Benson, department of surgery, Harper Hospital, Detroit, Mich.

"Lesser Known Uses of Thyroid Substance," Dr. Robert C. Moehlig, department of medicine, Harper Hospital.

"Surgery of the Thyroid Gland," Dr. George M. Curtis, department of surgery, Ohio State University College of Medicine.

"Clinical Pathological Conference," Dr. Bernhard Steinberg, Toledo Hospital Institute of Medical Research.

Luncheon Address: "A Doctor Makes a Critical Survey of the Medical Profession," Dr. Paul R. Hawley, chief medical officer, Blue Cross-Blue Shield Commission, Chicago.

"The Psychology of the Chronically Disabled Patient," Morton A. Seidenfeld, Ph. D., director of psychological services, National Foundation for Infantile Paralysis, New York.

"The Study of the Effects of Androgens on the Cardiovascular System," Dr. James B. Berardi, chief medical officer, Veterans Administration Regional Office, Chicago.

"Office Treatment of Allergic Patients," Dr. George L. Waldbott, Harper Hospital, Detroit.

"The Reason for Postgraduate Medical Education," Dr. Howard H. Cummings, chairman of postgraduate medical education, University of Michigan, Ann Arbor.

Hotel reservations may be made through Dr. Don F. Cameron, Wayne Pharmacal Bldg., Fort Wayne, Ind., or Dr. William Henry Gordon, 1102 David Whitney Bldg., Detroit, Mich.

Diseases of the Chest

The Council on Postgraduate Medical Education of the American College of Chest Physicians and the Laennec Society of Philadelphia announced a Postgraduate Course in Diseases of the Chest to be held at the Warwick Hotel, Philadelphia, Pennsylvania, February 28 through March 5, 1949. Application may be made through the Executive Offices of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Ill.

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The Stoneman Press will still have the type standing on the February Ohio State Medical Journal until the *10th* of the month, and will furnish reprints of your article at the following prices:

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Veterans Administration

According to local officials of the V. A., 97,510 Ohio veterans received out-patient medical treatments during the fiscal year ending June 30, 1948. Of this number, 58,301 veterans were treated by Ohio physicians on a fee-basis, while 39,209 were treated by V. A. staff members at V. A. facilities.

Following is a breakdown of statistics on the out-patient medical treatment program for the State of Ohio. The out-patient program is administered by V. A.'s Regional offices in Cincinnati and Cleveland under the supervision of the Columbus Branch Office which includes in its area the States of Michigan and Kentucky.

FEE BASIS TREATMENTS

State of Ohio: Individuals treated, 58,301; number of treatments, 153,263; total cost, $591,516; cost per individual, $10.14; cost per treatment, $3.85.

Cincinnati Regional Office: Individuals treated, 17,477; treatments, 63,410; total cost $238,073; cost per individual, $13.62; cost per treatment, $3.75.

Cleveland Regional Office: Individuals treated, 40,824; treatments, 89,853; total cost, $353,443; cost per individual, $8.66; cost per treatment, $3.75.

V. A. STAFF TREATMENTS

State of Ohio: Individuals treated, 39,209; treatments, 74,375. (No per-patient or per-treatment costs compiled for this group as they were taken care of in V. A. out-patient clinics.)

More than a million and a half veterans were treated during the fiscal year throughout the nation under the "home town" medical program, the national V. A. officials announced. The breakdown for the entire country follows:

Treatments averaged three per veteran, according to a V. A. report showing a total of 4,416,612 treatments by both V. A staff doctors and private physicians during the year ending June 30, 1948. Individuals treated numbered 1,626,169.

The private physicians treated 761,165 veterans, cooperating with the V. A. in a program designed to provide "home-town" care for disabilities attributed to wartime service. They were paid $11,437,739 for 2,735,429 treatments, establishing an average charge-per-treatment of $4.18 and a cost-per-veteran of $15.03.

V. A. staff doctors during the year handled 865,004 individual veterans and a total of 1,680,183 treatments. Since these were taken care of in V. A. out-patient clinics, located in the agency's hospitals and other field installations, no per-patient or per-treatment costs were compiled for this group.

* * *

Patients in Veterans Administration tuberculosis hospitals borrow nearly three times as many books and periodicals from hospital libraries as do patients in other types of V. A. hospitals, reports of the library service of V. A.'s Special Services revealed.

* * *

The number of compensation and pension cases on Veterans Administration rolls increased from 2,878,000 on October 1, 1948, to 2,879,000 on November 1—the first increase in six months. The peak was reached August 1, 1947, when V. A. reported 2,894,000 cases.

* * *

About 2,418,000 veterans were in schools and job training establishments under the G. I. Bill and Public Law 16 on November 1, 1948, Veterans Administration said. A year ago, the total was 240,000 higher, or 2,658,000.

* * *

Miss Esta H. McNett, chief of the Veterans Administration tuberculosis nursing section in Washington, D. C., announced her resignation effective in January, to become director of nursing at Mount Sinai Hospital in Cleveland.

* * *

By November 1, 1948, contracts had been let for 31 of the 91 Veterans Administration hospitals to be built under the billion dollar construction program. The entire project, expected to be completed in 1953, will result in some 51,000 additional beds for ill and disabled veterans.

Deciphering Signatures Delays Industrial Commission Program

Payment of fee bills in Industrial Commission claims is being delayed and in some instances payment has been made to the wrong doctor because the Commission's examiners cannot always correctly decipher the doctor's signature, according to Clark C. Grubbs, assistant supervisor of claims.

It is strongly recommended that **all signatures be either typed or stamped and then personally countersigned by the doctor.**

It is further recommended that where a number of doctors are associated in a group or clinic, one uniform signature be adopted, such as "Dr. Jones and Associates" or "Smith Clinic." The fee bill should then be countersigned by the doctor who treated the claimant. This procedure will greatly simplify the matter of payment of fee bills. One warrant and statement would then be made up by the Commission's Auditing Section for each group or clinic, instead of one for each individual doctor, as is now necessary in many cases.

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Army Surgeon General Announces Community Campaign

A program to unite professional and civic support in every community behind a campaign to meet "urgent manpower requirements" of the Army Medical Department through volunteers was announced early in January.

The program involves setting up Professional Manpower Committees in communities and coordinating them with the existing Military Manpower Committees which are already helping the general recruiting campaign. The medical program is part of the drive to obtain physicians, dentists, nurses and other medical specialists in order to meet the needs for medical care of the services.

The Surgeon General calls attention to the Selective Service Act which provides that "no person shall be inducted until adequate provision shall have been made for medical care." To date, the Medical Departments are meeting their obligation to provide adequate medical care to men coming into service; but as the physicians and dentists now on duty finish their service and are separated, others must be obtained to replace them. This shortage of medical personnel, if it continues, is viewed as a serious threat to national defense. The new program is an effort to obtain enough volunteers to meet the need.

In communities "outstanding physicians, surgeons, dentists and other leading medical specialists" will be asked to serve on Professional Manpower Committees, which will be set up as sub-committees to the Military Manpower Committees which are already assisting the Recruiting Service.

The plan has been worked out in cooperation with the American Medical Association and other national societies, and aid of local societies will be sought in working out local details, the Surgeon General assured.

The Council of the Ohio State Medical Association at its December 12 meeting approved the program as submitted to it by the Surgeon General, and recommended that each county medical society be prepared to name representatives on a local committee if requested to do so.

The Ohio Supreme Court upheld an appellate court in its action validating a bond issue for a joint township hospital for four Auglaize County townships. The question was taken to court after voters in 1946 approved a bond issue amounting to $500,000 for the institution. A common pleas court judge ruled that the board had proceeded irregularly, but his action was reversed by the District Court of Appeals. The Supreme Court upheld the appellate court.

Buckeye News Notes . . .

Amherst—Dr. C. H. Snell has been named child welfare program chairman of Lorain County Voiture No. 149, an American Legion organization.

Bellpoint—Dr. G. E. Robinson was named all American Golden Rule Honor Citizen of Delaware County for the month of November, and was the subject for a human interest article in the Delaware Gazette in December.

Cincinnati—Dr. Frank R. Dutra has decided to turn down the appointment as medical examiner for Westchester County, New York, and is remaining in Cincinnati as pathologist in the Hamilton County Coroner's office and at the Kettering Laboratory of the University of Cincinnati.

Cincinnati—Dr. Cecil Striker was elected president of the Public Health Federation to succeed Dr. William J. Graf. Dr. Carlos Schott was named first vice-president.

Cincinnati—Dr. Gerald H. Castle, surgeon for the Cincinnati Fire Department and a commander in the Navy during World War II, was elected first president of the Cincinnati Chapter, Association of Military Surgeons of the U. S. Other officers elected include: Dr. William H. Wolfram, Cincinnati, secretary; and Dr. Leon G. Tedesche, Cincinnati, treasurer.

Cleveland—Dr. John H. Dingle, professor of preventive medicine at Western Reserve University School of Medicine, and civilian director of the Army's Commission on Acute Respiratory Disease, has been placed in charge of the Army's program for extensive research in the field of streptococcus diseases.

Cleveland—Dr. Howard Dittrick was elected an honorary member of the Academy of Medicine of Cleveland at a recent meeting. Dr. Dittrick was recipient of the Academy's Distinguished Service Award in 1943. He is retiring as editorial director of the Cleveland Clinic.

Dayton—Dr. Elmer R. Arn has been elected a member of the board of governors of the American College of Surgeons.

Girard—Dr. Howard E. Mathay has been appointed medical director of the Carnegie-Illinois Steel Corporation's Youngstown district works. He will continue his practice in Girard.

Hillsboro—Dr. W. W. Hoyt, Highland County coroner since 1934, resigned effective January 1. Dr. J. Martin Byers of Greenfield was appointed to succeed him.

Lima—Dr. F. Miles Flickinger spoke on "Socialized Medicine" at the November meeting of the Memorial Hospital Alumnae held in the nurses' home.

Logan—Dr. H. E. M. Boocks represented the

Fifth CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE

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M. A. Blankenhorn	Ray Farquharson	George M. Lewis	LeRoy H. Sloan
Walter P. Blount	Edmund F. Foley	Louis R. Limarzi	Charles T. Stone
Barney Brooks	A. C. Furstenberg	Ovid Meyer	William D. Stroud
Paul C. Bucy	John W. Harris	James L. Poppen	Harry M. Weber
		Willis J. Potts	Henry W. Woltman

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medical profession at the first meeting of the planning committee for the newly organized Hocking County Health Council held recently.

Mariemont—Drs. Carl Minning, William S. Terwilliger and William D. DeVaux constitute a committee to promote a medical library at Our Lady of Mercy Hospital.

Marion—Dr. and Mrs. John T. Boxwell recently presented a scholarship to Kalamazoo College in Michigan in the name of Dr. Frank E. Bachelor, business manager emeritus of the college, and in memory of his wife.

Marion—Dr. Frederick R. Mautz, Western Reserve University School of Medicine, spoke on "Surgical Problems in Infants and Children" at the November meeting of the Seventh District, Ohio State Nurses Association.

Perintown—Dr. George E. Rockwell, president of the American College of Allergists, gave several lectures at the fall graduate course in Allergy at the University of Oregon Medical School.

Ravenna—Dr. J. T. Villani was guest speaker at a meeting of the Portage County Council of Health and Social Agencies, where he spoke on the subject of tuberculosis.

Shelby—Dr. O. Roy Kackley of Galion was principal speaker at a recent meeting of the Rotary Club and discussed the crippled children's program.

Springfield—Dr. Gustin C. Ullery spoke before a meeting of the Kiwanis Club on the subject "Cancer and Radiation."

Toledo—Drs. David L. Friedman, George W. Bascom and Richard Hotz, of the Academy of Medicine of Toledo and Lucas County, and Mr. Robert W. Elwell, executive secretary, were named on the Toledo Army Advisory Committee.

Upper Sandusky—Dr. John M. Thompson is the newly elected coroner of Wyandot County.

Xenia—Dr. Robert D. Hendrickson has been named president of the Greene County Chapter of the Ohio State University Alumni Association.

Michigan Course

The annual Michigan Postgraduate Clinical Institute will be held Wednesday, Thursday, Friday, March 23-25, in Detroit, Michigan. This three-day regional scientific conference will feature demonstrations and lectures by outstanding doctors of medicine from the United States and Canada. Members of the State Medical Societies of Michigan, Ohio, Indiana, Illinois, Wisconsin and the Province of Ontario are invited to the Institute. E. C. Texter, M. D., 1005 Stroh Building, Detroit, Michigan, is chairman of the committee on housing.

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Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

Dr. Samuel R. Gendelman, Manchester, and Dr. Hazel L. Sproull, West Union, were re-elected president and secretary-treasurer, respectively, of the Adams County Medical Society. Dr. Robert B. Ellison, Peebles, was elected vice-president; Dr. S. J. Ellison, West Union, is delegate, and Dr. R. L. Lawwill, Seaman, alternate.

BUTLER

Dr. Herbert Warm, Hamilton, took office as president of the Butler County Medical Society in January. Other officers are: Dr. Louis H. Skimming, Middletown, pres.-elect; Dr. Edward Keating, Hamilton, secy.-treas.; Dr. Charles T. Atkinson, Middletown, and Dr. Harry M. Lowell, Hamilton, delegates; Dr. Donald M. Blizzard, Middletown, and Dr. John Borelli, Hamilton, alternates.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CHAMPAIGN

Officers of the Champaign County Medical Society for 1949 are the following Urbana physicians: Dr. F. E. Lowry, president; Dr. Lewis Inskeep, vice-pres.; Dr. Isador Miller, secy.-treas.; Dr. D. C. Houser, delegate; and Dr. E. R. Earle, alternate.

DARKE

Officers of the Darke County Medical Society for 1949 are: Dr. John S. Meyers, Versailles, president; Dr. Paul G. Lenhert, Arcanum, vice-pres.; Dr. Maurice M. Kane, Greenville, secy.-treas.; Dr. J. E. Gillette, Versailles, delegate; and Dr. Charles E. Geckler, Greenville, alternate.

MONTGOMERY

Incoming president of the Montgomery County Medical Society for 1949 is Dr. E. R. Arn, who took office Jan. 1 with the following other Dayton physicians: Dr. H. R. Huston, vice-pres.; Dr. H. D. Cassel, pres.-elect; Dr. Paul Troup, secy.; Dr. M. D. Place, treas. Delegates are: Dr. M. D. Prugh, Dr. R. D. Dooley, Dr. R. S. Binkley and Dr. A. W. Carley. Alternates are: Dr. L. E. Baker, Dr. Ned D. Shepard, Dr. R. C. Doan and Dr. R. E. Pumphrey.

SHELBY

Members of the Shelby County Medical Society elected the following officers who took office in January: Dr. R. E. Paul, Botkins, president; Dr. Russell L. Wiessinger, Sidney, vice-pres.; Dr. C. B. Conover, Sidney, secy.-treas.; Dr. Wiessinger, delegate; and Dr. H. E. Crimm, alternate.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

CRAWFORD

Dr. M. L. Helfrich, Galion, is the new president of the Crawford County Medical Society. Other officers are: Dr. C. A. Adams, Galion, vice-pres.; Dr. M. E. Switzer, Galion, secy.-treas.; Dr. J. S. Kiess, Bucyrus, delegate; and Dr. J. W. Arnold, Bucyrus, alternate.

LOGAN

Dr. O. C. Amstutz, Bellefontaine, was re-elected president of the Logan County Medical Society for 1949. Other officers are: Dr. Douglas W. Beach, Huntsville, vice-pres.; Dr. John B. Traul, Bellefontaine, re-elected secy.-treas.; Dr. Hobart L. Mikesell, delegate; and Dr. W. F. Mills, Bellefontaine, alternate.

MARION

Members of the Marion County Academy of Medicine elected the following officers who took office Dec. 14: Dr. A. E. Morrison, Marion, president; Dr. Robert T. Gray, Prospect, vice-pres.; Dr. William H. Whitehead, Marion, re-elected secy.-treas.; Dr. Morrison, delegate; and Dr. Gray alternate.

SENECA

Seneca County Medical Society officers for the coming year are: Dr. G. H. W. Bruggemann, Fostoria, president; Dr. W. A. Daniel, Tiffin, vice-pres.; Dr. D. J. Mariea, Fostoria, secy.-treas.; Dr. Roswell F. Machamer, Tiffin, delegate; and Dr. Paul Leahy, Tiffin, alternate.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

FULTON

Dr. R. W. Reynolds, Fayette, and Dr. Paul I. Geer, Metamora, were re-elected president and secretary-treasurer, respectively, of the Fulton County Medical Society. Dr. C. F. Murbach, Archbold, is the vice-president; Dr. R. E. Merrill, Delta, delegate; and Dr. E. R. Murbach, Archbold, alternate.

HENRY

Dr. W. R. Ward, Holgate, is the new president of the Henry County Medical Society, with the following other officers: Dr. Thomas Quinn, Napoleon, vice-pres.; Dr. R. L. Gilson, re-elected secy.-treas.; Dr. Bernard L. Johnson, Deshler, delegate; and Dr. Quinn, alternate.

OTTAWA

Ottawa County Medical Society officers for the coming year are: Dr. LeRoy L. Belt, La-Carne, president; Dr. H. O. Beeman, Port Clin-

ton, vice-pres.; Dr. Gordon R. Ley, Port Clinton, secy.-treas.; Dr. G. A. Boon, Oak Harbor, delegate; and Dr. C. R. Wood, Port Clinton, alternate.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

New officers of the Ashtabula County Medical Society are: Dr. M. R. Martin, Geneva, president; Dr. S. A. Burroughs, Ashtabula, vice-pres.; Dr. J. B. Hall, Geneva, secy.-treas.; Dr. E. H. Merrell, Geneva, censor; Dr. P. J. Collander, Ashtabula, delegate; and Dr. H. A. Tagett, Ashtabula, alternate.

LAKE

Lake County Medical Society officers for the coming year are the following: Dr. Frederick J. Dineen, Painesville, president; Dr. Paul E. Reading, Painesville, vice-pres.; Dr. Thomas E. Byrne, Mentor, secy.-treas.; Dr. M. G. Carmody, Painesville, delegate; and Dr. B. S. Park, Painesville, alternate.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

MAHONING

The following officers were elected by members of the Mahoning County Medical Society and took office on Dec. 21: Dr. John N. McCann, president; Dr. G. G. Nelson, pres.-elect; Dr. V. L. Goodwin, secy.; Dr. L. H. Getty, treas.; Dr. E. J. Wenaas, Dr. I. C. Smith and Dr. W. M. Skipp, delegates. All are of Youngstown.

SUMMIT

Dr. David J. Roberts took office as president of the Summit County Medical Society in January with the following other Akron physicians as officers: Dr. John D. Brumbaugh, pres.-elect; Dr. Donald I. Minnig, secy.; Dr. Arthur F. Dorner, treas. Delegates are Dr. R. E. Pinkerton, Dr. Kurt B. Weidenthal, Dr. L. A. Witzeman and Dr. E. W. Burgner. Alternates are Dr. R. M. Bartlett, Dr. M. F. Bossart, Dr. Louis E. Brown, Jr., and Dr. F. A. Smith.

TRUMBULL

Trumbull County Medical Society officers for 1949 are the following: Dr. Densmore Thomas, Niles, president: Dr. E. G. Caskey, Mineral Ridge, vice-pres.; Dr. Charles W. Mathias, Niles, secy.-treas.; Dr. E. G. Kyle, Newton Falls, delegate; and Dr. S. J. Shapiro, Warren, alternate.

Seventh District

(COUNCILOR: R. J. FOSTER, M.D., NEW PHILADELPHIA)

BELMONT

Newly elected officers of the Belmont County Medical Society are: Dr. D. M. Creamer, Bellaire, president; Dr. Harvey H. Murphy, Barnesville, vice-pres.; Dr. Bertha M. Joseph, Martins Ferry, secy.-treas.; Dr. Creamer, delegate; and Dr. Murphy, alternate.

COSHOCTON

The Coshocton County Medical Society elected the following officers for the coming year: Dr. F. C. Beattie, president; Dr. W. R. Agricola, vice-pres.; Dr. H. W. Lear, secy.-treas.; Dr. E. J. Booth, delegate; and Dr. G. W. Stelzner,





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alternate. All are of Coshocton except Dr. Agricola who is of Newcomerstown.

HARRISON

Officers of the Harrison County Medical Society for the year are: Dr. Gerald F. Vorhies, Scio, re-elected president; Dr. Carl F. Goll, Hopedale, vice-pres.; Dr. Richard W. Weiser, Jewett, secy.-treas.; Dr. Goll, delegate; and Dr. Vorhies, alternate.

JEFFERSON

Dr. Walter A. Cunningham is the new president of the Jefferson County Medical Society. Other officers are: Dr. James L. Childs, vice-pres.; Dr. S. L. Burkhardt, secy-treas.; Dr. Max H. Rosenbloom, delegate; and Dr. John Y. Bevan, alternate.

TUSCARAWAS

Members of the Tuscarawas County Medical Society elected the following officers for the year 1949: Dr. C. M. Dougherty, New Philadelphia, president; Dr. William E. Hudson, New Philadelphia, vice-pres.; Dr. H. F. Wherley, New Philadelphia, secy.-treas.; Dr. J. S. Adler, Strasburg, delegate; and Dr. Edgar Davis, Jr., Dover, alternate.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

ATHENS

Taking office in January were the following Athens physicians of the Athens County Medical Society: Dr. Beatrice Postle, president; Dr. A. A. Baldwin, vice-pres.; Dr. C. R. Hoskins, secy.; Dr. P. J. Woodworth, delegate; and Dr. Baldwin, alternate.

MORGAN

Dr. C. E. Northrup, Sr., and Dr. E. G. Rex of McConnelsville were re-elected president and secretary-treasurer, respectively, of the Morgan County Medical Society. Dr. A. A. Coulson, McConnelsville, is delegate; and Dr. Henry Bachman, Malta, alternate.

MUSKINGUM

Dr. Harry C. Powelson is the new president of the Muskingum Academy of Medicine with the following other officers who took office Dec. 1: Dr. W. B. Faircloth, vice-pres.; Dr. Beatrice T. Hagen, re-elected secy.-treas.; Dr. George C. Malley, delegate; and Dr. Paul A. Jones, alternate. All are of Zanesville.

NOBLE

Officers of the Noble County Medical Society for 1949 are the following Caldwell physicians: Dr. Charles F. Thompson, president; Dr. N. S. Reed, vice-pres.; Dr Edward G. Ditch, secy.-

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treas. Dr. Ditch also was designated delegate and Dr. Thompson, alternate.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

GALLIA

The following Gallipolis physicians are officers of the Gallia County Medical Society for the year beginning Oct. 1, 1948: Dr. N. Howard Foster, president; Dr. Homer B. Thomas, re-elected secy.-treas.; Dr. Charles E. Holzer, Jr., delegate; and Dr. Foster, alternate.

PIKE

Officers of the Pike County Medical Society for 1949 are: Dr. Charles A. Clifton, Piketon, president; Dr. A. M. Shrader, Waverly, vice-pres.; Dr. Charles L. Critchfield, Waverly, secy.-treas.; Dr. Paul H. Jones, Stockdale, delegate; and Dr. W. L. McCaleb, alternate.

SCIOTO

Officers of the Hempstead Academy of Medicine for the coming year are the following Portsmouth physicians: Dr. R. M. Gault, president; Dr. C. H. Allen, vice-pres.; Dr. C. L. Pitcher, secy.-treas.; Dr. W. A. Quinn, delegate; and Dr. Dow Allard, alternate.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

DELAWARE

The following officers of the Delaware County Medical Society took office in January: Dr. Harold W. Davis, president; Dr. M. S. Cherington, vice-pres.; Dr. F. M. Stratton, secy.-treas.; Dr. E. V. Arnold, delegate; and Dr. J. G. Parker, alternate, Dr. Davis is of Ashley; the others are of Delaware.

MADISON

Officers of the Madison County Medical Society for the coming year are: Dr. Sol Maggied, West Jefferson, president; Dr. W. T. Bacon, London, vice-pres.; Dr. Herman E. Karrer, Plain City, secy.-treas.; Dr. E. S. Crouch, London, delegate; and Dr. Maggied, alternate.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ERIE

Dr. Emil J. Meckstroth and Dr. H. G. Lehrer were re-elected president and secretary-treasurer, respectively, of the Erie County Medical Society for the coming year. Other officers are Dr. C. J. Reichenbach, vice-pres.; Dr. Ross M. Knoble, delegate; and Dr. V. A. Killoran, alternate. All officers are of Sandusky.

HOLMES

Dr. Luther W. High was re-elected president of the Holmes County Medical Society for the

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coming year and Dr. Owen F. Patterson was re-elected secretary-treasurer. Dr. N. P. Stauffer is delegate and Dr. A. J. Earney, alternate. All are of Millersburg.

HURON

Huron County Medical Society officers for 1949 are the following: Dr. Clyde J. Cranston, Wakeman, president; Dr. Charles H. Edel, Norwalk, vice-pres.; Dr. George F. Linn, Norwalk, secy.-treas.; Dr. Owen J. Nicholson, Norwalk, delegate; and Dr. William H. Kauffman, Willard, alternate.

LORAIN

Lorain County Medical Society officers for the coming year are: Dr. Leonard A. Stack, Lorain, president; Dr. R. C. Novatney, Elyria, vice-pres.; Dr. L. H. Trufant, Oberlin, re-elected secy.-treas.; Dr. George A. Hoke, Elyria, and Dr. A. C. Siddall, Oberlin, delegates; Dr. George D. Nicholas and Dr. Theodore Berg, both of Elyria, alternates.

MEDINA

Medina County Medical Society officers for 1949 are: Dr. J. G. Martin, Wadsworth, president; Dr. W. B. Houston, Valley City, vice-pres.; Dr. Frederick Kornfeld, Medina, secy.-treas.; Dr. R. F. Fasoli, Brunswick, delegate; and Dr. G. T. Wagner, Hinkley, alternate.

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

ASHTABULA

Members of the Auxiliary to the Ashtabula County Medical Society met Tuesday, December 14, at Hotel Ashtabula, where dinner was served to fifteen. Mrs. Frank Veroni was named president-elect to fill the vacancy created by the resignation of Mrs. H. A. Tagett. Mrs. C. J. Streicher was named vice-president, to replace Mrs. Veroni. It was decided to adopt a needy family as the Christmas goodwill service. Mrs. C. C. Roller and Mrs. Tagett served as hostess-chairmen for the dinner.

ERIE

Erie County Medical Society Auxiliary gave a tea at the Columbus Avenue residence of Mrs. E. J. Meckstroth for the nursing personnel of Providence and Good Samaritan Hospitals. Mrs. C. E. Swanbeck of Huron, Mrs. W. R. Fenker, Mrs. H. W. Lehrer, and Mrs. Hugo Sarchet, poured. Mrs. Meckstroth was assisted by Mrs. E. C. Alexander, Mrs. Ross Knoble, Mrs. Fred Schoepfle, Mrs. C. J. Reichenbach, Mrs. A. J. Groscost and Mrs. William Burger. Members' wives and widows of Erie County doctors were guests at the annual meeting of the Erie County Medical Society at Plum Brook Country Club. Following the dinner, Dr. William Burger, chair-

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man of the affair, presented a corsage to each of the honored guests. After the presentation, the group was entertained by a professional magician and then enjoyed dancing.

FRANKLIN

On Saturday, December 11, at Mees Hall, Capital University, the Woman's Auxiliary to the Columbus Academy of Medicine presented Miss Dorothy Biddle, Garden Club Editor of *Flower Grower*, the home garden magazine. This group gave garden enthusiasts of Columbus and vicinity the opportunity to hear Miss Biddle and also help them in raising funds for rehabilitating handicapped children.

PICKAWAY

Members of the Woman's Auxiliary to the Pickaway County Medical Society were entertained at a luncheon Tuesday, December 28, in the home of Mrs. J. M. Hedges of Circleville. Places were set for ten. A business meeting followed the luncheon.

ROSS

Members of the Woman's Auxiliary to the Ross County Academy of Medicine assembled for dinner, Thursday evening, January 6, at Allyn's Dining Room. Nineteen members were present and Mrs. Richard Zollinger of Columbus was a guest.

Mrs. Edwin H. Artman presided at the monthly business meeting which followed. Various committee reports were given and Mrs. John Franklin, legislative chairman, discussed the disadvantages and dangers of socialized medicine. Mrs. Walter E. Kramer was elected delegate to the State convention to be held April 19, 20 and 21 in Columbus with Mrs. George Cooper of Clarksburg as alternate.

SANDUSKY

Welcoming the Sandusky County Medical Auxiliary to her home on Wednesday evening, December 22, Mrs. F. L. Moore, opened her home for the meeting and Christmas party. Mrs. M. M. Riddell presided at the business meeting. Mrs. A. F. Schultz, reporting on the Sandusky County Welfare Committee, was the speaker. Mrs. Schultz related highlights of a talk given by Ray Horn, state educational department representative, given at the meeting. He discussed the exceptional child, of which there are a half million. He stressed that every community has a challenge in meeting the problem of helping the exceptional child. Mrs. C. L. Fox reported briefly on various projects the group may select for the new year. The members discussed these and a definite project was scheduled to be chosen at the January meeting. After the gift exchange, refreshments were served.

TUSCARAWAS

Twenty-four members of the Tuscarawas County Medical Auxiliary and two guests attended the



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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 21, March 21. Vaginal Approach to Pelvic Surgery, one week, starting Feb. 14, April 4.

OBSTETRICS—Intensive Course, two weeks, starting March 7.

MEDICINE—Intensive Course, two weeks, starting April 4. Personal Course in Gastroscopy, two weeks, starting March 7.

PEDIATRICS—Intensive Course, two weeks, starting April 4.

DERMATOLOGY—Formal Course, two weeks, starting May 2. Clinical Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

ROENTGENOLOGY—Lecture and Diagnostic Course, two weeks, starting the first Monday of every month. Clinical Course, starting the third Monday of every month.

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group's annual covered dish Christmas party at the Brightwood home of Mrs. M. W. Everhard. The business session was conducted by the president, Mrs. C. J. Miller. Plans were made and a committee appointed for the year's Yule project. The auxiliary provided Christmas treats for each patient at the Tuberculosis Sanitarium. Miss Phyllis Hansberger, New Philadelphia librarian, presented an interesting and informative talk on "Christmas Customs in Germany." A gift exchange closed the evening's program.

Licensed Through Endorsement by State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states:

June 21, 1948—Robert W. Colopy, Cleveland, St. Louis Univ.; David H. Dorton, Jr., Kenton, Univ. of Louisville; Gerald A. Erhard, Newark, Univ. of Pittsburgh; Alan J. Gathright, Toledo, Georgetown Univ.; Edwin G. Olmstead, Dayton, Univ. of Illinois; James R. O'Malley, Cleveland, St. Louis Univ.; James E. Printy, Toledo, Georgetown Univ.; Maurice D. Sachs, Cleveland, Univ. of Berne; Earl H. Stanley, Jackson, Univ. of Louisville; Jerome B. Stechschulte, Youngstown, St. Louis Univ.; Richard A. Steinbach, Cincinnati, Univ. of Georgia; Clarence J. Styblo, Cleveland, St. Louis Univ.; Franklin G. Wade, Belpre, Temple Univ.; Raymond E. Wehr, Cincinnati, Univ. of Cincinnati; Jerrold L. Wheaton, Jr., Nelsonville, New York Medical College.

August 10, 1948—Buell L. Ashmore, Chillicothe, Univ. of Louisville; Jaime M. Benavides, Cleveland, Univ. of Penna.; Doris T. Braislin, Cleveland, Woman's Med. College of Pa.; Bruce L. Brown, Ravenna, Univ. of Rochester; Irving L. Colvin, Edon, Indiana Univ.; William F. Dowdell, Columbus, Jefferson Medical College; John P. Doyle, Lakewood, St. Louis Univ.; Norman M. Glazer, Cleveland, St. Louis Univ.; Leslie H. Gould, Worthington, Coll. of Med. Evangelists; Robert P. Green, Akron, State Univ. of Iowa; Arnold Gross, Hamilton, Univ. of Buffalo; Gorden W. Hasse, Cleveland, Univ. of Ill.; Charles F. Jones, Jr., Metamore, Medical College of Va.

Robert H. Mabry, Springfield, Univ. of Georgia; Edmund A. Massullo, Youngstown, St. Louis Univ.; French H. McCain, Cleveland, Washington Univ.; Joseph A. Mendelson, Dayton, Temple Univ.; Mark F. Moots, Canton, Georgetown Univ.; J. Richard Nolan, Parma, St. Louis Univ.; Russell L. Oyer, Sugarcreek, Univ. of Ill.; John G. Powers, Cleveland, Loyola Univ.; Edgar F. Ryan, Cleveland, St. Louis Univ.; Richard H. Schaefers, Nelsonville, Univ. of Nebraska; Hans G. Schlumberger, Worthington, Univ. of Penna.; Carl P. Wisoff, Dayton, Har-

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vard Medical College; Frederic H. Wood, Columbus, Albany Medical College; Jefferson C. Woodbury, Akron, Indiana Univ.

October 5, 1948—Stewert I. Adam, Dayton, Jefferson Medical College; John A. Barasch, Dayton, Univ. of Kiel (Germany); Victor J. Boerger, Edgerton, Indiana Univ.; Robert J. Bowersox, Cleveland, Univ. of Mich.; George M. Boyden, Toledo, Univ. of Colo.; Margaret W. Bridwell, Columbus, Louisiana State Univ.; Walter R. Burt, Milford Center, Univ. of Louisville; Floyd C. Carden, Zanesville, Meharry Medical College; Vincent J. Coviello, Toledo, Univ. of Siena (Italy); Hatcher A. Day, Columbus, Meharry Medical College; Earl J. Farrell, Jr., Cambridge, Univ. of Louisville; Roberta Follansbee, Shaker Heights, Univ. of Minn.; Ann H. Ford, Perrysburg, Univ. of Penna.

Frederick J. Grigsby, Dayton, Meharry Medical College; John G. Guju, Youngstown, Marquette Univ.; Gerald Hart, Cleveland, Meharry Medical College; Charles M. Harvey, Jr., Cincinnati, Univ. of Texas; David C. Humphrey, Cleveland, Univ. of Kansas; William E. Jenkinson, Cincinnati, Indiana Univ.; Herbert A. Jones, Jr., Canton, Wayne Univ.; William S. Jordan, Jr., Cleveland Heights, Harvard; Louis D. Kacalieff, Cleveland, Washington Univ.; Felix E. Karpinski, Jr., Cleveland, Jefferson Medical College; James L. Kingsland, Columbus, Howard Univ.; William E. Kishman, Lorain, New York Univ.; Wesley E. Knaup, Springfield, Univ. of Arkansas; Daniel W. Kramer, Oberlin, Univ. of Rochester.

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December 14, 1948—Joseph C. Avellone, Lakewood, Western Reserve Univ.; Donald G. Casterline, Cincinnati, Tufts College; Lintner E. Clark, Toledo, Indiana Univ.; Martin J. Cook, Springfield, Univ. of Chicago (Rush); Ralph I. Cottle, Jr., Warren, Duke Univ.; Margot Deckert, Columbus, Univ. of Berlin; John W. DeVore, Columbus, Univ. of Oklahoma; Donald B. Effler, Cleveland, Univ. of Michigan; Louis Gelb, Yellow Springs, Columbia Univ.; Roy D. Goodwin, Wilmington, Univ. of Louisville; Robert G. Janes, Findlay, Univ. of Western Ontario; Carl T. Korsmo, Akron, Temple Univ.; Walter W. Lang, Kent, Georgetown Univ.; Lewis Lehrer, Cleveland, Jefferson Medical College.

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Activities of the Editor

Dr. Jonathan Forman, Editor of *The Journal*, accepted an invitation to take part in the section on nutrition and the soil, National Conference on Rural Health, scheduled in Chicago, February 4 and 5. Following are some other recent activities in which Dr. Forman engaged:

He addressed the combined meeting of the staff of St. Ann's Maternity Hospital and the general practitioner section of the Columbus Academy of Medicine on the subject, "Nutritional Requirements of Pregnant Women."

At a meeting of the alumni, friends, faculty and student body of the Wilmington College, he spoke on "Conservation's Challenge to Education."

He addressed a recent meeting of the Junior Association of American University Women in Columbus.

He spoke before a luncheon meeting of the Clintonville Medical Club on the subject, "Soil-Health Relationships."

COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, April 19-22.

American Academy of General Practice Annual Scientific Assembly, Cincinnati, March 7-9.

American College of Physicians, Annual Session, New York City, March 28-April 1.

Annual Conference of County Society Presidents, Secretaries and Committeemen, Columbus, March 20.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

How To Live Longer

IN the present day search for the means to improve the health of our people, we have needed for sometime now a critical analysis of the facts of death—just what kills people; and at what age. We have need to review just what we can do to prevent the untimely deaths each year of some 250,000 of our people.

We now have such an analysis, written in clear, simple language colored with a bit of preaching that drives home the fundamental fact that personal health is always a personal responsibility. Here, for the first time, is a popular but accurate account of the disease hazards to which people in the United States are most likely to succumb. By detailing the pertinent facts concerning these diseases, the personal responsibility which each one of us holds for his or her own life and good health is demonstrated. **(How to Live Longer** by Justus J. Schifferes, $3.00. *E. P. Dutton & Company, Inc.)* The author, a teacher of hygiene and a lay scientist who served for ten years as a managing editor of a medical journal, points toward a practical method of preserving about a quarter of a million lives that otherwise would be, and are, sacrificed annually to ignorance and neglect. If the majority of our people were to read this book, which confines itself pretty largely to demonstrated facts well-known in the field of medicine and hygiene, a quarter of million deaths could be prevented each year in the United States.

The figure of 250,000 unnecessary deaths each year in the United States is startling. Perhaps, I ought to tell you how the author arrives at it. The greatest killer of all—diseases of the heart, blood vessels and kidney—that is, diseases of the heart and blood vessels, now accounts for about 650,000 deaths each year. The author concludes that probably the best we can do is to save ten per cent of the lives that might have been needlessly sacrificed to this killer. But this would mean 65,000 lives saved.

Here I personally would like to play with hunches as well as statistics. If all of us would eat only whole grain cereals and whole grain breads and vegetables and fruits grown on fertile soil, avoid sugar and all sweets made therefrom, we would no longer be insulting the lining of our hearts and blood vessels with the products of incomplete combustion; all of the fuel used to furnish energy to our bodies would be efficiently burned to carbon dioxide (a gas) and water. There would be nothing left with which to "carbonize" or poison our blood vessels. This would have prevented most of the degenerative diseases of the circulatory system in the first place. If you are a middle-aged, stocky-built man, you may well have a tendency towards high blood pressure. In this event, it is doubly important that you follow these dietary suggestions. As Schifferes points out, one person in four has a tendency to high blood pressure and three-fourths of this group neglect themselves and go ahead and develop high blood pressure. If your parents died of heart disease, a stroke, or kidney disease, it is all the more probable that you too have a tendency to high blood pressure. If so, keep your weight down, eat moderately of lean meat, green and yellow vegetables often in raw form, and raw fruits (citrus or tomato daily), avoid sweets and fats as though they were poison. The author says nothing about tobacco, but Raymond Pearl, the great student of health statistics, some years ago showed that smoking fairly heavily takes about seven years off the average smoker's life.

There seems to be general agreement that, if we took care of ourselves as the American Medical Association and the American Cancer Society would have us do, we would prevent at least 65,000 deaths from cancer each year. So far, we have 130,000 deaths that occur each year through our personal neglect to use for ourselves the facts that are known today.

Accidents now rate third in the list of killers of Americans. The total is 100,000 lives a year. "It has been stated without challenge in publications of the American Medical Association and elsewhere, that '90 per cent of all accidents are preventable and that 80 per cent of the accidents that happen to children are the result of some fault of omission or commission on the part of an adult.'" If we are to make a saving of lives here (and we can cut the figure in half if we will—it has been done in communities that have tried), our educational program must be much more intense and more motivating. For the results of the National Safety Council reveal that with the rise of automobiles and good roads (1913-1949), there has been only a drop of about ten per cent in the over-all record of accidental deaths in this same period. The author insists, and rightly so, that through a concentrated

effort we can cut the present accident control by 50,000 lives a year.

To summarize, so far we have found that we could save 180,000 lives annually in just these three main categories alone.

The author then takes a look at tuberculosis, syphilis, and pneumonia, and states that the possibility of saving 50,000 lives a year is a very conservative estimate with the modern efforts of our local public health officers and the new drugs which have so recently come into the hands of us physicians.

If diabetic patients were to take care of themselves as their physicians are instructing them to do, this would mean that 17,500 persons would be saved each year from the wasting, gangrenous, or coma-struck death.

If we would heed the medical profession's instructions to pregnant women—even with little or no attention paid to diet—we would get another 25 per cent improvement in the premature birth mortality—or so the author thinks, and we agree with him that it would mean a saving of another 10,000 lives. Most of the recent studies on the effects of a good diet on pregnancy would indicate that more nearly 40,000 of those tiny premature babies would be carried to term and live to grow up.

The psychiatrists feel that they could save some 3,500 of 20,000 individuals who commit suicide each year in this country if the victims would have given them a chance.

If we tally up these life-saving potentials, we find a total of 260,000 unnecessary deaths each year. The author conservatively struck the figure in round numbers of one-quarter of a million.

If we take a close look at the ten principal causes of death in this country today, we come up with the conclusion that the people themselves without any more governmental help could, if they wished, outwit 80 per cent of all deaths in the United States.

Most of the time your reviewer has been writing about increasing the life span. We have at all times emphasized the desirability of adding Life to our Years while we are adding Years to our Lives. Consideration of the life expectancy in a given population is the reverse way of looking at its death rates. Professor Schifferes has chosen to drive home the lesson of personal responsibility in this matter by looking at the picture from the side of the death rates.

Certain it is that death comes to us all. It, however, should not come until after we have had a long and happy life. The end, too, should be free from disease with its pain and sufferings. Our bodies should, after many years of wear, just run down quietly and Death should come as a welcomed sleep to a totally worn out body.

We know that death will come with the certainty of time—but disease is not a necessary evil. This brings us to the consideration of how long one should live. The author has taken us into the whole field of mammalogy to confirm the usual statement of biologists that mammals should have, as a rule, a life expectancy of five times the length of time it takes them to mature. He points out that "a dog full-grown at two years, has a life expectancy of some 12 years. A cat, reaching maturity at one and a half years, has an expectancy of 10 years. A horse, mature at four years, has 21 years more ahead. If human beings, then attaining full physical stature at 25, were to follow the same curve of slow decay as observed in many of the lower animals, Mankind should enjoy an average, normal life span of 150 years.

The author also takes us back into the pages of history where we find that as near as can be ascertained, prehistoric man enjoyed a life span of about 18 years; while in the days of the Roman Empire longevity had increased only to 22 years. In the middle ages it reached 35. From here on there was but little improvement in the life span until we came to the golden age of Industrial Capitalism (1890-1945). The plumber then gave us a toilet connected to the city sewer and placed in a warm room. This did away with most intestinal infections in adults. The rest of the enteric infections were done away with by the sanitary engineer who brought a sterilized water supply of uncertain quality to our town people. The ice man also made a great contribution when it became practical to keep milk on ice from the time it was drawn from the cow until it was served. Children stopped dying with summer complaints and cholera infantum. Shortly after this, the biochemist succeeded in giving us physicians formulae for feeding the baby that were greatly improved, as was the general diet of our people. By 1900, the death rate had dropped to 17.2 per 1,000 population and by 1947 to 10.1. The author, however, begs us not to be satisfied with this excellent record.

He wants us to realize that much of the gain in longevity has come about through an improvement in child and infant mortality rates. A great deal more, however, has come from our ability to control our environment and to raise our standards of living. All of this implies what your reviewer has been preaching up and down the length and breadth of this land for ten years now, that Health is not a medical problem, it is an economic one. As we pass from present-day State Capitalism to embark upon the proposed socialistic program, we have dissipated our real wealth and our national resources to a point where our death rate may well begin to mount as our living standards are lowered—housing, clothing, contentment and above

all good food as the factor that makes for good health. These can have an impact on our death rate which will be far greater than anything that the medical profession can do. All this is in spite of the fact that Professor Schifferes has shown how we physicians can prevent 250,000 untimely deaths of our citizens each year if the American public will just follow the advice of us physicians.

It is your reviewer's firm belief that we can prevent more than three times that number of deaths by the institution among all of our people of a sound diet balanced from unrefined and unspoiled foods grown on mineral-rich soils containing all of the bio-elements essential to optimal health for plants, trees, and domestic animals.

This book contains a wealth of information which everyone of us should study and digest in order that we can preach the maintenance of good health as a more desirable alternative to State Medicine.

* * *

Shock and Allied Forms of Failure of the Circulation, by H. A. Davis, M.D., ($12.00. *Grune & Stratton, New York City*) contains 583 pages of information. It has been written for the surgeon or the surgical specialist, the obstetrician, the anesthesiologist, and the medical man, all of whom do not know at what moment they will be faced with a case of failure of the circulation. When this ubiquitous tragedy happens, decisions have to be made promptly in minutes—which does not permit prolonged analysis of the case. Consequently, a study of this volume during leisure hours, may help you save a life.

Lung Dust Lesions Versus Tuberculosis, by Lewis Gregory Cole, M.D., ($10.00. *American Medical Films, Inc., 8 Church Street, White Plains, New York*) presents a great deal of material, clinical, pathologic, and roentgenologic in an attempt to explore the controversial field of the effects of exposure to dust in an attempt to solve some of the social and economic problems with justice to labor and to management alike. All of us who see patients who have been exposed to dust for a long time cannot any longer do them justice unless we take time off to study this great wealth of material very carefully.

Bovine Tuberculosis, Including a Contrast with Human Tuberculosis, by John Francis, M.R.C.V.S., ($5.00. *Staples Press, Inc., New York City*) is a monumental task carried out in a praise-worthy manner. The work deals with bovine tuberculosis as a problem of rural health. His emphasis on the comparative pathology makes it of general interest. All students of this disease, of comparative pathology, public health, and agriculture economics will want to own this compresensive summary.

Health Instruction Yearbook, 1948, compiled by Oliver E. Byrd, M.D., ($3.50. *Stanford University Press, Stanford, California*) is up to its expected standard. Each year for six years now I have looked forward to getting this volume on Health Education. This volume is based upon selections from 1514 articles of which 321 were chosen for condensation and publication. It is interesting to note that the *Journal of the American Medical Association* yielded 43 articles, *Congressional Record* 19, and *American Journal of Public Health* 15, because it gives some idea of where to look for important new material for health education.

Outline of Histology, by Margaret M. Hoskins, Ph.D., and Gerrit Bevelander, Ph. D., ($3.50. Second Edition. *C. V. Mosby Company, St. Louis, Mo.*) has, for good reasons, proved a popular laboratory manual.

Cancer of the Esophagus and Gastric Cardia, edited by George Pack, M.D., ($5.00. *C. V. Mosby Company, St. Louis, Mo.*) presents the newer developments with the extension of radical surgery into the field in all major medical centers.

A Synopsis of Physiology, by A. Rendle Short, M.D., C.L.G. Pratt, M.D., and C. C. N. Vass, M.D., ($6.00. Fourth Edition. *Williams & Wilkins Company, Baltimore, Maryland*) is a summary of the human aspects of the subject in small compass. It is a means for making a quick survey of *human* physiology.

New and Nonofficial Remedies, 1948, ($1.50. *J. B. Lippincott Company, Philadelphia*) is the current Report of the Council on Pharmacy and Chemistry of the American Medical Association.

It's a Sin To Be Fat—When You Don't Have To Be, by Ann Williams-Heller, ($2.00. *Greystone Press, New York City*) is by the author of *Cooked To Your Taste* and *Soybeans from Soup to Nuts.* As would be expected, this book is long on menus and recipes. As one who is proud of his accomplishments as a cook, your reviewer can recommend this book. One of the difficulties in a reducing program is to avoid wanting in food items and the mental depression that goes with it. Here is a way out.

What You Should Know About the Drugs You Use, by Austin Smith, M.D., ($3.00. *Revere Publishing Company, New York City*) is a popular bit of advice on self-medication with such titles as "Vim, Vigor, and Vitamins," "Sleep Pills," "Laxatives Can Cause Constipation," "A Doctor in Every Family," "When Not To Change Treatment," "That Latest 'Cure,'"—and a dozen other equally attractive titles and chapters.

The Ohio State Medical Journal

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JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Postoperative Management of Patients with Gastrectomy

MacDONALD WOOD, M. D.

THE management of patients at the Cincinnati General Hospital during their immediate and early postoperative period following gastrectomy will be presented.

FLUID BALANCE

The control of fluid balance is of great importance in the treatment of patients immediately after operation. Acute deficits occurring preoperatively have usually been corrected as most patients undergoing gastrectomy are operated upon as elective cases. Acute deficit occurring during the procedure can be fairly well recognized and corrected. It has been our plan to give 500 to 1000 cc. of citrated whole blood during the operation, and to continue the intravenous therapy upon return of the patient to the ward. Water and salt loss during operation have usually not been great, and can be stabilized with the administration of a liter of 5 per cent glucose in saline. The minimum adult daily requirement of fluid has generally been considered to be 3000 cc. and we maintain a minimum intake of 3000 to 3500 cc. per day during the immediate postoperative period unless some contraindication is present.

Daily maintenance of the six basic nutritional substances, water, salts (electrolytes), protein, carbohydrates, fat, and vitamins (Elman[1]) is essential, and they are administered parenterally until oral feedings are sufficient. Amino acids are readily available in parenteral form, often in combination with glucose and saline. In some commercial preparations a liter of fluid contains 5 per cent hydrolyzed protein, 5 per cent glucose, and 0.2 per cent saline in aqueous solution. Daily administration of one to two liters of parenteral amino acids one liter of 5 per cent glucose in water, and one-half liter of 5 per cent glucose in saline (0.85 per cent) will give the minimum daily requirement of 100 gms. of protein, 150 gms. of glucose, and 5 to 7 gms. of sodium chloride.

Intravenous therapy is continued for four to six days or until oral feedings are sufficient. Occasionally a whole blood transfusion is given on the third or fourth postoperative day to maintain hematocrit and protein levels.

In order to determine the proper fluid balance for each patient it is necessary to keep accurate daily records of urinary output and amount of gastric material obtained per Wangensteen suction. The average daily urinary output should be 1000 to 1200 cc., although 800 cc. daily for the first forty-eight hours has not been considered insufficient. Close observation of the bladder during the immediate 18 to 24 postoperative hours is necessary to prevent overdistension. Early ambulation has helped patients to void spontaneously. In those individuals

The Author

● Dr. Wood, Dayton, Ohio, is a graduate of Northwestern University Medical School, 1943; diplomate of the National Board of Medical Examiners; chief surgical resident, Veterans Hospital, Dayton; and assistant professor of clinical surgery, University of Cincinnati.

Presented before Section on Surgery at 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, April 1, 1948.

who have received spinal anesthesia, however, catheterization has occasionally been necessary.

THE LEVINE TUBE

It has been our custom to insert a Levine tube through the nose into the stomach the night before operation and during the operative procedure manipulate the tip of the tube to lie just above the anastomosis. Continuous suction through the Levine tube is maintained postoperatively for 36 to 48 hours by means of a Wangensteen apparatus, and all aspirated material is collected in a separate trap bottle in the suction system. The amount and character of this material are recorded daily. In patients with partial gastrectomy this is usually less than 300 cc. and of dark bloody character on the first postoperative day. The amount is usually less on the second postoperative day but the material has changed to a dark green, and if the tube is left in longer than forty-eight hours the character often is dark yellow to golden yellow. In patients with total gastrectomy the suction is maintained for seventy-two hours, the amount usually being less than 200 cc. per day. It has been our general rule to give a cc. of 5 per cent glucose in saline for every cc. of vomitus or aspirated material per Levine tube to maintain the chloride balance.

The criteria for the time of removal of the Levine tube are: (1) The onset of audible peristalsis, which indicates return of the bowel to normal motility and is also good evidence of the absence of peritonitis: (2) the change of character of the material aspirated; (3) the amount of material aspirated.

FEEDING

Patients are given nothing by mouth until the Levine tube is removed thirty-six to forty-eight hours postoperatively. Water is then started in amounts of one ounce every hour for a twenty-four-hour period. If this is tolerated well the amount of fluid given is increased from day to day until the patient is receiving four ounces each hour and then a four-feeding surgical soft diet is started and given for two or three days. If this is tolerated well he is then given a full Meulengracht diet. The following has been the routine oral intake and diet at the Cincinnati General Hospital for patients following gastrectomy:

First 36 to 48 hours — Nothing by mouth

3rd postoperative day — Water oz. i every hour

4th postoperative day — Water oz. ii on the even hour
Fat-free broth, tea, albumin water, bland fruit juices, or buttermilk oz. ii on the odd hours

5th postoperative day — Hourly feeding alternating water with broth, tea, etc., increased to oz. iii

6th postoperative day — Hourly feedings oz. iv adding 1 coddled egg in the morning and evening and eggnog at noon. Start supplementary aminoacids (oral) in three divided doses to total 150 gms. protein

7th postoperative day — Water ad lib. and 4 feeding surgical soft diet. Supplementary aminoacids and vitamins

8 a. m.	4 p. m.
Cereal oz. iii	Milk & cream oz. iii
Milk & cream oz. iii	Coddled egg
Coddled egg	

12 noon	8 p. m.
Milk toast 1 slice	Milk & cream oz. viii
Eggnog oz. viii	or
Custard oz. iv	Eggnog oz. viii or Malted milk oz. viii

10th postoperative day — Full Meulengracht diet in four divided feedings.

In patients having a total gastrectomy the above diet is used but started twenty-four to thirty-six hours later than patients with partial gastrectomy. It is most important when the surgical soft and Meulengracht diets are begun that they are given in five or six feedings per day. Frequent intake is necessary to provide adequate absorption, and patients often need to be maintained on multiple feedings for nearly a year, after which time the majority are able to eat three meals at the accustomed times during the day without distress.

A Stamm jejunostomy has been used in patients who have had total gastrectomy, in patients who showed chronic nutritional deficit prior to operation, or in patients who develop a malfunctioning stoma and require an additional route of intake. An adequate jejunostomy diet supplying basic nutrient substances is given.

Vitamins are given almost routinely postoperatively in the following amounts daily: Vitamin C, 500 mgm.; thiamine HCl, 5 mgm.; riboflavine, 5 mgm.; and niacin 100 mgm.

AMBULATION

Progressive ambulation with assistance is utilized for the first three days, after which time the patients can usually walk short distances by themselves. We have noted that early ambulation has definitely made recuperation more rapid.

Patients with partial gastrectomy are usually discharged on the fourteenth or sixteenth postoperative day, and patients with total gastrectomy usually leave on the thirtieth or thirty-fourth postoperative day.

TREATMENT OF COMPLICATIONS

A routine procedure in the postoperative care of patients at the Cincinnati General Hospital, which has proven to be as valuable as maintenance of the fluid balance, has been the frequent daily examinations of the patient's chest and extremities. The postoperative temperature should rarely rise above 100° F., and any rise in temperature, pulse, or respiration should be a signal of possible pulmonary or vascular complication. Hyperventilation of the lungs by means of a stimulating amount of carbon dioxide

every three to four hours until the patient is responsive and cooperative, followed by encouragement of deep breathing, has greatly decreased postoperative pulmonary complications. The use of oxygen has been necessary only in those patients who were chronically ill, who underwent extensive procedures, or had persistent respiratory distress. Avoidance of constricting bandages across the chest and abdomen is most important, as restriction in motion of the lower chest results in incomplete aeration of the lung bases.

Of the many complications that may occur the most frequent have been respiratory, and may consist of atelectasis, pneumonia, pulmonary edema, or pulmonary emboli. The alertness of the surgeon in early recognition of atelectasis with institution of immediate treatment has warded off many serious complications. When atelectasis is noted, the encouragement of coughing by the patient with support of the abdomen by an assistant can often dislodge obstructing bronchial mucus plugs. If this measure fails, placing the patient upon the uninvolved side with his head lowered and his feet elevated, and encouraging him to cough while concomitantly pounding the chest wall on the involved side has often been rewarded with success. If atelectasis persists, however, bronchoscopy is utilized immediately and carried out repeatedly in event of recurrence. Persistent tracheobronchial mucus secretions are treated by insertion of a small catheter through the nose into the trachea as recommended by Alexander and Haight. This procedure can usually keep the tracheo-bronchial tree clear of mucus, but if it fails to maintain a clear airway bronchoscopy must be utilized.

Anticoagulant therapy in the form of heparin and dicumarol is started at the appearance of the earliest signs of thrombophlebitis.

An infrequent but disturbing complication is recurrent bleeding, and in those patients it is necessary to keep the gastric pouch as empty as possible with continuous suction per Levine tube and with evacuation of any clots, as distension of the stoma may allow persistent bleeding from the vessels at the point of anastomosis. The persistence of bloody material on Wangensteen suction alerts the surgeon, but only by careful clinical observation and frequent checks on the hemoglobin and on the character of material aspirated can one determine the need and time for reoperation.

GASTRIC RETENTION

Patients in whom gastric retention persists in the early postoperative period present a perplexing and difficult problem. In those individuals who maintain a large gastric retention for several days, the cause has usually been ascribed to edema and swelling, and in these cases emptying of the gastric pouch is delayed for only a short period. In those patients who still have obstruction for seven or more days, however, a mechanical etiology is most likely. It has usually been considered in our clinic that persistent obstruction has been due to some technical error in the operation. Ingestion of a small amount of barium will determine whether obstruction is at the stoma or in the upper small bowel. We have had only infrequent cases with malfunctioning gastroenterostomy stoma. I recall one patient, with a benign pyloric ulcer, who maintained a large gastric retention for a week following partial gastrectomy with a Polya anastomosis. A small amount of barium given per mouth showed complete retention for three hours with filling of only the proximal loop. Re-exploration revealed a patent stoma into proximal and distal loops and a few friable non-obstructing adhesions over the distal loop, A Stamm jejunostomy was done and satisfactory fluid balance was maintained. Obstruction of the stoma persisted for a total of thirty-eight days after which time apparently normal emptying of the stomach occurred. He has remained asymptomatic for almost three years. His last upper gastro-intestinal series one year ago revealed normal and rapid emptying of the gastric pouch. Allen and Welch[2] report several cases of malfunctioning stoma, and cite a case that remained obstructed for a total of fifty days. Graham[3] also reports a personal case with persistent obstruction for forty-three days. It has been considered by most observers that re-operation with attention directed toward the stoma is to be condemned, but that a jejunostomy is most assuredly indicated in all cases with a persistent malfunctioning stoma.

DUODENAL FISTULA

The occurrence of duodenal fistula following gastrectomy has been rare at the Cincinnati General Hospital, which has been due, we believe, to the careful layer closure of the duodenal stump. The duodenal stump is closed over either a Kocher or a Carmalt clamp, with a Parker-Kerr suture of "00" chromic catgut, which is tightened upon removal of the clamp, and is continued back on the stump as a right angle Cushing suture. If closure has been difficult, it can be reinforced by suturing the serosa of the duodenum to the capsule of the pancreas with interrupted Lembert sutures of fine "0000" black silk. I can recall only one patient during the past five years who developed a duodenal fistula and that was due to considerable difficulty in closure of the stump; the anterior duodenal wall was sutured to the ulcer and pancreas posteriorly. His fistula developed on the third postoperative day and persisted for 80 days, when it closed spontaneously. A duodenal fistula presents two important problems,

(1) maintenance of fluid balance, and (2) protection of the skin from erosion. A jejunostomy is imperative, as oral intake must be limited and there must be an avenue for feeding of aspirated secretions from the fistula. Use of dilute hydrochloric acid instilled through an additional tube in the fistula to neutralize the alkali has been advocated by Potter. Various protecting sub-

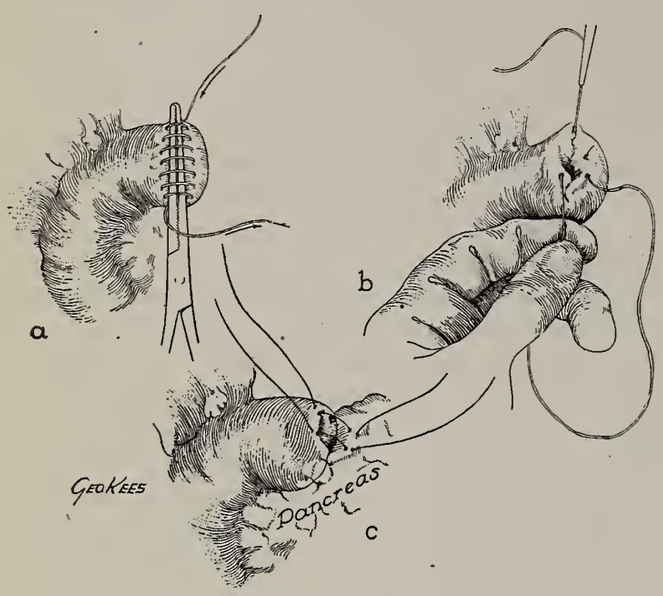


Figure 1. Closure of duodenum (refer to article).

stances such as peptones, Fuller's earth, and aluminum paste have been used for application around the fistulous opening. Placing the patient upon his abdomen on a Bradford frame will keep digestive juices from accumulating on the skin. A duodenal fistula usually closes, but if it persists for months operation with reimplantation of the fistula into bowel may be required.

ABDOMINAL WOUND

Careful toilet of the abdominal wound and painstaking aseptic open anastomosis has kept wound infections down to a minimum. Wound dehiscence and wound evisceration occur infrequently and are treated by secondary closure with through and through silver or stainless steel wires (Reid[4]). Peritonitis from leakage at the point of anastomosis has been very rare in our experience.

LATE MANAGEMENT

The late postoperative management of patients with gastrectomy has usually been controlled by the Medical and Gastric Services at the Cincinnati General Hospital. The recurrence of bleeding, development of marginal ulcer, gastrojejunocolic fistula, or stricture at the site of anastomosis in total gastrectomies will usually come to the attention of the surgeon.

CONCLUSION

In conclusion, the management of patients at the Cincinnati General Hospital during their immediate and early postoperative period, has been presented with discussion of the maintenance of fluid balance, dietary regimen, and treatment of complications.

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Tell Them Not To Use Tourniquets

Perhaps every physician has had the experience of having someone rushed to his office bleeding furiously from a trivial wound of an extremity because some incompetent individual had applied a tourniquet improperly. Usually a constricting cloth is applied proximal to the wound with sufficient pressure to occlude the veins completely, but too loosely to occlude the arteries. The net result is that the entire arterial blood supply has no place to go except to spurt from a wounded vein.

Such a situation almost invariably occurs among employees of large corporations, who have been taught a smattering of first aid. Farmers, housewives, and others who have not had the benefit (?) of such teaching, seldom make this mistake. They properly try direct pressure on the wound as the first means of stopping the bleeding and almost always are successful.

This recent case is typical. A railway section hand whose spike maul threw a steel fragment into the radial muscle group of his forearm and produced profuse venous bleeding, had a large improperly constricting handkerchief twisted about his arm by a fellow workman. He estimated that he lost 3 quarts of blood in the half-hour which was required to transport him to my office. He was covered with blood, as were his friends and their automobile. Even though this man's estimate of blood loss may have been too high, he had lost a lot of blood.

A properly constricting towel was wrapped about his arm immediately and he was placed on a table. Several very bloody cloths and handkerchiefs were unwrapped from the forearm and the wound was exposed. The towel was removed from the arm and profuse bleeding began. The constricting handkerchief was removed from the arm and the bleeding diminished. The extremity was elevated and the bleeding stopped.

This was the opportunity. Three astonished sections hands were told: First, try direct pressure to wounds; secondly, elevate the extremity; thirdly, don't even think about a tourniquet until pressure and elevation of the limb have been tried; fourthly, if you have to use a tourniquet get it tight enough to stop the bleeding.—CARL MINNING, M. D., Williamsburg, Ohio.

Antibiotics and the Prevention of Postoperative Pulmonary Complications*

STANLEY O. HOERR, M. D.

ALTHOUGH postoperative pulmonary complications are rarely fatal in themselves, they can be an annoyance and potential hazard to the patient, and a worry to the surgeon. There can be little doubt that improvements in the technique of anesthesia, in the preoperative preparation of the patient, and in postoperative care, have all had their effect in reducing the severity of such complications as do occur. On the other hand, when research standards are utilized in the analysis of patients undergoing surgical procedures, it can be shown that postoperative pulmonary complications occur about as frequently today as heretofore, although the majority may be of such a mild and transient character that they might ordinarily be entirely overlooked unless they were specifically searched for. It was to be hoped that early ambulation would significantly decrease the incidence of these complications, and yet careful studies show that this hope has not been realized. It is the purpose of this paper to point out that yet another possible aid in the prevention of postoperative pulmonary complications, penicillin, has little if any value as a prophylactic.

The Author

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THE FIRST FOUR DAYS

Ninety per cent of all postoperative pulmonary complications will have their onset within the first four postoperative days. Many different terms have been applied to these early complications. "Ether pneumonia" has long since disappeared as a descriptive term, after the demonstration that most of these complications are neither a true pneumonia, nor due primarily to any anesthetic agent. Some writers simply speak of "cough" as the complication in those patients displaying this symptom to any appreciable degree, but who have very little else in the way of signs and symptoms. Others refer to an "acute bronchitis" in patients exhibiting cough, fever, and coarse rales, but who have an essentially negative X-ray of the lungs.

Atelectasis is in actuality probably the commonest early complication, usually making its appearance within the first two or three days. The lobular or patchy type is the most usual form, and it is usually mild in nature, self-limited and of short duration. The usual signs are fever, not necessarily very high, cough (although this may not be conspicuous), rales and diminished breath sounds. There is always a drop in vital capacity, although in the lobular type there is hardly ever any respiratory difficulty. The X-ray findings may be minimal, and may be almost identical with those of a bronchopneumonia. In fact, many roentgenologists will not distinguish between a bronchopneumonia and a lobular atelectasis. A clinical distinction is of no great value provided it is borne in mind that for practical purposes the average early postoperative bronchopneumonia behaves in the same fashion as a lobular atelectasis.

Atelectasis, of course, may involve a lobe or an entire lung. This last occurrence is a comparative rarity today, but gives the dramatic and unforgettable picture of "massive collapse" —an abrupt onset with high fever and rapid pulse, marked respiratory distress, dullness and absent breath sounds over the affected side, and a shift of the trachea and mediastinum toward the collapsed lung.

COUGH

Whatever these early complications are called, whether cough, bronchitis, atelectasis or bronchopneumonia, it is generally agreed that they are not a primarily infectious process, but result from several different mechanical factors: The drying out or thickening of the bronchial secretions; diminished aeration of the lungs due to splinting of the muscles of respiration (and this is largely the result of pain in the operative incision); and inefficient coughing and clearing of the bronchial tree for the same reason— a painful wound. On the heels of a mechanically induced atelectasis there may follow a true infectious process—a bronchopneumonia or pneumonitis, or in extreme and neglected cases an abscess or empyema. With this view of the etiology of the early pulmonary complications, one would expect little of penicillin or any other antibiotics as preventatives, since by their nature they are not directed at the mechanical factors

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which produce the complication. On the other hand, once an atelectasis (or "bronchopneumonia") is established, there is every reason to expect penicillin to modify or ameliorate the infectious process which may follow if the underlying condition is not promptly relieved.

In contrast to the foregoing complications, small or large pulmonary infarcts are unlikely to appear before the eighth or ninth postoperative day. The diagnosis of pulmonary infarct has improved immeasurably in the last decade with the realization that small infarcts may behave like pleurisy. It is not to be expected that any antibiotic can effectively prevent a pulmonary infarct.

There are several widely recognized factors predisposing to the development of a postoperative pulmonary complication. In most reported series, males are cited as developing these complications two or three times as frequently as females. The cause is not known, but it may be related to the proportionately greater drop in vital capacity which takes place in males after some operations. In surgery of the upper abdomen, operations on the biliary tract, and particularly the stomach, have been repeatedly shown to have an incidence of 10 to 25 per cent of postoperative pulmonary complications. This is a higher incidence than that following surgery in any other part of the body. The reason seems to be the geographical proximity of the wound to the muscles of respiration, so that there is usually a drastic decrease in the vital capacity as a result of the pain of normal breathing, and for the same reason interference with productive coughing. Finally, a patient undergoing surgery in the presence of an acute inflammatory process within the abdomen, such as a perforated ulcer or an acute cholecystitis, is far more likely than the average to develop a chest complication.

MATERIAL

The present study is based upon a series of patients undergoing operations upon the upper abdomen in 1947 at University Hospital, Ohio State University. The series includes operations upon the biliary tract, vagus resection (all done through the abdomen), gastric resection, and closure of acute perforated ulcer. Table 1 gives the number of the individual procedures and the number of pulmonary complications following each. A fundamental division has been made between so-called "elective" surgery, and "acute" surgery in which the timing of the operation was to some extent, at any rate, out of the surgeon's hands. The adverse effect of an acute inflammatory process is strikingly shown, since even in this small series the difference between the incidence in the "elective" group and the "acute" group is statistically significant. The further breakdown on this table results in groups too small to make percentage comparisons of value, but it may be seen that the lowest incidence of complications has taken place in the groups with elective biliary surgery and elective gastrectomy for ulcer. In gastrectomy for cancer, where patients are usually suffering from some degree of malnutrition, the incidence is higher. The high incision employed for transabdominal vagus resection, together with the fact that most of the operating is done at the diaphragm, partially accounts for the higher incidence in this group. Furthermore, four-fifths of the vagus resection patients were males.

Table 1
Upper Abdominal Operation—1947
Postoperative Pulmonary Complications

Procedure	No. of Cases	No. of POPC	
"Elective" Surgery			
Cholecystectomy ± choledochostomy	52	3	
Transabdominal vagus resection ± PGE	24	6	
Gastrectomy for cancer	6	3	
Gastrectomy for ulcer	5	1	
	87	13	(15%) *
"Acute" Surgery			
Cholecystectomy ± choledochostomy **	11	4	
Closure perforated ulcer	6	3	
Cholecystostomy **	2	1	
Gastrectomy for acute hemorrhage	1	1	
	20	9	(45%) *

* Significant Difference.
** Operations for Acute Cholecystitis.

In interpreting the high incidence of postoperative pulmonary complications shown in this series, two facts must be borne in mind: 1. These groups of patients were specifically selected for this study, since it was known that they would present the greatest number of chest complications; 2. Many of the complications listed here were of such a mild character that they might easily have been overlooked if it were not for the fact that our residents and internes have been trained to suspect a pulmonary complication on very little evidence. Additional proof of this last statement is to be found in the fact that there were no deaths in the entire series which could be attributed to the pulmonary complication, nor was there any pulmonary complication which could be regarded as grave.

Table 2
Upper Abdominal Operations—1947
Postoperative Pulmonary Complications

Classification	No. of Cases "Elective"	"Acute"	Total
Atelectasis	6	5	11
Bronchopneumonia	4	1	5
"Pneumonitis" or "pleuritis"	2	1	3
Suspected infarct	—	1	1
Pleural effusion	1	1	2
	13	9	22 *

* Only one death; not related to pulmonary complication.

In Table 2 the various complications are classified.

As previously mentioned, a differentiation between atelectasis and bronchopneumonia depends largely on the interpretation of the X-ray, which in turn depends on the predilections of the individual roentgenologists who read the films. From a clinical standpoint, they can be regarded as synonymous when occurring in the early postoperative phase. Two patients with pleural effusion are included for the sake of completeness; the cause of the effusion was not determined, but in neither case was there a demonstrable antecedent lesion of the lungs. The one death in this group of twenty-two patients was from peritonitis, and not related to the chest complication. It is noteworthy that there is only one case of suspected infarct in this series, and no case of proven infarct. This is a very low incidence, and may be partially attributable to a concurrent study of phlebothrombosis and thrombophlebitis at University Hospital, resulting in much emphasis on the earliest possible diagnosis of these conditions, and the use of prompt anticoagulant therapy once the diagnosis was made.

In Table 3 is seen a cross analysis of the 87 elective cases with respect to sex, age, and

Table 3
Upper Abdominal Operations—1947
Postoperative Pulmonary Complications
87 Elective Operations

	No. of Cases	No. of POPC	%POPC
Sex: Male	36	9	25%
Female	51	4	8%
Age: 50 years or more	40	5	13%
49 years or less	47	8	17%
Routine Penicillin	26	4	15%
No Routine Penicillin	61	9	15%

routine penicillin as a prophylactic. In this group, males developed a pulmonary complication three times as often as females—a significant figure statistically even in this small group. Age appeared to have little bearing, although almost half the patients were more than fifty years old. There is likewise no obvious beneficial effect from routine penicillin, and it can be seen that four patients who were receiving penicillin developed pulmonary complications, resulting in an incidence identical with that of the group which did not receive penicillin.

In Table 4 is a brief tabulation of the eight patients in the entire series who developed a pulmonary complication while they were receiving penicillin. In most instances the penicillin was started on the day of operation, but in every instance before the pulmonary complication had appeared. The dosage employed was 30,000 to 50,000 units every three hours. In the elective group it was given as a prophylactic; in the acute group it was used as therapy for an established inflammatory lesion in several instances. Whatever the reason for its use, it may be seen that in these cases penicillin did not appear to have any deterrent effect on the occurrence of an atelectasis or bronchopneumonia. Again, the two patients who developed an effusion are listed for completeness, although there was

Table 4
Upper Abdominal Operations—1947
Patients Developing a Postoperative Pulmonary Complication During Penicillin Therapy

Sex	Age	Diagnosis	Procedure	Complication
M	27	Duodenal ulcer	Vagus resection	Atelectasis
M	38	Ca. of Stomach	Gastrectomy	Broncho-pneumonia
M	82	Ca. of Stomach	Gastrectomy	Pleural effusion
F	84	Cholecystitis and common duct stone	Cholecystectomy and chole-dochostomy	"Pneumonitis"
F	50	Acute chole-cystitis	Cholecystectomy and chole-dochostomy	Atelectasis
M	54	Duodenal ulcer with acute hemorrhage	Emergency gas-trectomy	Broncho-pneumonia
F	66	Acute chole-cystitis	Cholecystectomy	Atelectasis
M	74	Perforated ulcer	Closure	Pleural effusion

no evidence of its origin from a lesion of the lung. It may be mentioned in passing that two of the patients listed in this table were in their eighties, and one in his seventies—a time of life when one is glad to settle for a minor pulmonary complication as the only aftermath of major surgery.

If penicillin is not an effective preventive of postoperative pulmonary complications, what prophylaxis should be employed? General measures will include the best possible preoperative preparation of the patient that circumstances permit. Surgery is to be avoided during an active upper respiratory infection. Further measures should be directed against the mechanical factors which bring about the early postoperative complications. The anesthesia should be as technically perfect as possible, and individualized to the patient's needs. The bronchial tree should be sucked dry at the conclusion of lengthy or stormy anesthesia. Postoperatively, the patient should be encouraged to breathe deeply by any suitable means (we employ the vital capacity measurement as one method of getting the patient to take a deep breath); the patient should be encouraged to cough, to move about, and to walk at the earliest opportunity. The use of respiratory depressants like morphine should be kept at a minimum. Intercostal nerve analgesia with a long-acting agent like nupercaine in oil may prove to be a worth-while adjunct in operations where the wound is in the upper abdomen or chest. Antibiotics and the sulfonamides, however, are best used only for a specific indication, or after a pulmonary complication has become manifest.

SUMMARY

In a study of 107 patients undergoing operations of the upper abdomen in 1947 at University

Hospital, it has been shown that despite improvement in the technique of anesthesia and in preoperative and postoperative care and the introduction of early ambulation, postoperative pulmonary complications are still relatively frequent. Although these complications are usually mild and self-limited, and although none of the chest complications in the series studied could be regarded as grave, they are none-the-less a potential source of danger. It has been shown that such complications can develop during the administration of penicillin in therapeutic dosage. Since the chest complications developing during the first few days after an operation are probably a result of mechanical factors, rather than a primary infection, prophylaxis should be aimed at controlling these factors. Penicillin therapy is advisable once a pulmonary complication is established, to cope with the infection which may follow an unresolved atelectasis. But penicillin in itself is not an effective prophylactic against postoperative pulmonary complications.

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Cutaneous Toxicity of Dihydroxydichlordiphenylmethane

The incubation period of dihydroxydichlordiphenylmethane in our patient was 12 days During this interval the dermatitis remained indolent. It seemed to be getting better. When the incubation period had been satisfied, the dermatitis suddenly spread from the initial location with violent signs. Simultaneously, id lesions appeared on the legs. Patch tests on the arm were positive, indicating that a generalized sensitization had occurred. Recently a patient was observed with a generalized, patchy, vesicular eczematization. After the dermatitis had cleared, a patch test with Watkins Unguent was strongly positive. To our surprise, this proprietary, too, contained dihydroxydichlordiphenylmethane. This patient was additional proof that this chemical is a powerful sensitizer—L. Edward Gaul, M. D., and G. B. Underwood, M. D., Evansville; Jrnl. of Indiana State Medical Assn.; Vol. 42, No. 1, January, 1949.

Bronchogenic Carcinoma

Patients in the cancer age presenting symptoms suggesting cancer should immediately have a roentgen examination of the chest. In 95 per cent of the cases in which bronchogenic carcinoma proves to be present, the diagnosis may be suspected from the roentgenogram alone. In all cases in which the disease is suspected, a routine bronchoscopic examination should be made. At an early stage this is the only method by which tissue can be obtained for the establishment of a positive microscopic diagnosis. A positive diagnosis can be made in about 90 per cent of the cases in the inoperable group. Bronchography or the intratracheal instillation of iodized oil followed by roentgenographic examination may reveal partial or complete occlusion of a bronchus. Not infrequently the bronchus is tapering in character. This is an important diagnostic finding and in the absence of a satisfactory bronchoscopic examination may lead one to the correct diagnosis.

Aspiration biopsy of the primary tumor is usually not advisable. Definite seeding of the pleura from aspiration was noted in one of our cases. Sputum aspirated at the bronchoscopic examination should be studied cytologically, particularly with Papanicolaou stain, as this method often leads to the correct diagnosis. Routine cytologic examination of the sputum in suspected bronchogenic carcinoma should be carried out. Often the patient will present palpable lymph nodes in the supraclavicular and cervical chain which at times may show metastasis. The main diagnostic aid in diagnosing bronchogenic carcinoma is to suspect it.

Every effort should be made to determine the operability of the patient, as needless operations discredit surgical treatment. By the use of the bronchoscope, a biopsy can be made which will determine the type of tumor, and this information will aid in determining the type of treatment. When undifferentiated and "oat cell" tumors are present, operation is not indicated. The operability of the patient is a factor which must be determined by the individual surgeon.

The only satisfactory treatment for bronchogenic carcinoma is surgical removal of the affected lobe or entire lung. More recent opinions concerning therapy advocate pneumonectomy instead of lobectomy. As in all cancer, if early diagnosis is made, pneumonectomy can be performed with favorable prognosis. Radiation has been advocated by some, but the consensus at the present time is that this measure is only palliative. The high voltage roentgen therapy, 1,000,000 k.v.p., may change this view somewhat. —Kenneth A. Morris, M. D., and Wilbur C. Sumner, M. D., Jacksonville, Fla., Jrnl. of Florida Medical Assn., Vol. XXXV, No. 7, January, 1949.

Electro-Coma Therapy: A Six-Year Follow-Up of a Series of Private Psychotic Patients Treated with Electro-Coma Therapy

J. L. FETTERMAN, M. D., VICTOR M. VICTOROFF, M. D., and E. BREGMAN, A. B.*

SIX years ago one of us reported a study of some seventy patients treated by electro-coma therapy during 1941.[1] During the following year an additional number of patients were treated amounting to a total of 130. Our results at that time were remarkably successful, particularly in cases of depression, and in schizophrenia loaded with affect. Nevertheless, it was stated that we must allow the test of time to enable us to reach a sound appraisal. The present study which is based upon a six to seven-year follow-up is an attempt to furnish such long-term appraisal. Our experience may serve to calm the doubts entertained by certain psychiatrists and general practitioners as to the true worth of this mode of treatment.

The Authors

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MATERIAL

Our study deals exclusively with private patients who were psychotic rather than psychoneurotic. They were treated at the Post Shaker Sanitarium, The University Hospitals, Cleveland, Ohio, and The Windsor Hospital in Chagrin Falls. All told, we started treatment on 130 patients, some of whom discontinued treatments for personal, financial, and other reasons. Several cases were excluded from the study on the basis of insufficient data. Also some of the case histories were lost because the senior author had been in the war service and there were several unavoidable changes of address. More serious is the fact that we were unable to locate or trace some of the patients who had moved away. Thus this paper will present the outcome in only 100 patients.

Our case material included chiefly patients diagnosed as depressions and schizophrenias, ranging in age from 17 to the early seventies. It included both sexes. Our patients were from all walks of life, from various racial, educational and social levels. This group was entirely hospitalized except for an occasional maintenance treatment given in the Emergency Rooms of the University Hospitals.

As we are about to consider the results obtained, let us stress the fact that we shall attempt to give broad general experiences rather than detailed mathematical percentages. A study of this kind is beset with difficulties, it involves figures, patients, and particularly the attitudes of the authors. Figures, though sanctified by some force of numerical truth, may be misleading in two ways. First is the inequality of certain numerical facts, and secondly the prejudice of the hand that records them. For instance, some patients who are listed as failures were known to be chronic cases with a poor prognosis. Treatment was started only at the insistence of a desperate family pleading for aid, and only after an open discussion of the poor prognosis in such a case. Obviously the results in such patients were often unfavorable and may be attributed to the inherent deep-set malady. Certainly a melancholy patient, despondent and suicidal, who can be restored to well-being by a brief course of treatment and who can live many years as a happy, constructive member of society is more of a credit to a procedure of treatment and the result is not offset by the lack of response of a case of dementia praecox whose deviation began in the pre-adolescent period. Yet from a purely numerical point of view each case would be balanced against the other.

The matter of evaluation of results was also a problem. Although we wrote to every patient who had been treated many failed to reply to our letters of inquiry. Some persons who have been through a psychotic episode are very reluctant to be reminded of or drawn into the situation of the previous psychosis. Others show a hesitancy in writing which we could term a

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psychic agraphia. As a consequence, we did not learn about the present status of some patients until we had made telephone communications. An appraisal of the present status in such instance was dependent upon the subjective statements of the patient.

The evaluation of the result obtained and the general conclusions drawn may be influenced by the emotional bias of the authors. With a full realization of this tendency, however, we have tried to give our facts and conclusions in line with actual experience and observation.

IMMEDIATE AND EARLY RESULTS

The immediate effect of electro-coma therapy is the conspicuous benefit which has been obtained by most patients. Quite uniformly such treatment tends to relieve anxiety, induces calmness, and facilitates a closer touch with reality. It is quite common to observe after several electro-coma reactions that fears are allayed, tenseness and doubts reduced, relaxation and metabolism improved. Thus, most patients sleep better, become more cheerful, gain in weight, and become amenable to outside influence. Such improvement, to be sure, is but physiological. Skeptics may scoff at such a result, obtained mechanically and without precise knowledge of the physiological and dynamic principles involved. Yet such skepticism fails to do justice to the practical benefits of suffering alleviated, assaultive tendencies reduced, self-destructive impulses erased. If electro-coma therapy did no more than this it would still constitute a significant therapeutic measure. However, our later results in agreement with those reported by Kalinowsky and Hoch,[2] Taylor,[3] Norman, et al.,[4] Hinko and Lipshutz[5] reveal hospital stay reduced, behavior improved, suicide practically eliminated, and a percentage of recovery far greater than that which was formerly obtained by spontaneous and symptomatic methods.

We consistently observed the tendency of electro-coma therapy to elevate the mood of the patient. It is remarkable to see the changing countenance altering day by day from the frozen, tense, drawn features to the sparkling eyes and laughing smile of a cheerful person. The voice becomes louder and the step firmer, the attitude hopeful and forward-looking. This may occur even before there is appreciable clouding of memory and forgetfulness. It is our impression that such improvement takes place by actual stimulation of diencephalic brain function rather than through destruction.

Such improvement is not attained without certain difficulties and complications. The most conspicuous of these are the traumatic complications, namely, fractures. In our series there were three patients who suffered severe fractures. One developed a bilateral fracture of the mandible during the second treatment—a complication that we have not seen described in the literature nor which we have re-experienced in seven years of treatment. The two others had rather severe forms of the common compressions of the bodies of the mid-thoracic spine, confirmed by X-ray examination. Undoubtedly, there may have been other cases of fracture but we did not deem it advisable to make routine X-rays of all patients.

As the treatment program continued it was common to observe clouding of memory. Fortunately, this tended to clear gradually following completion of treatment. In some cases the memory disturbance was marked particularly for the events just preceding and during the period of treatment. In a few instances the patient had difficulty with memory for some weeks or even longer after the treatment course was ended. However, we do not recall any case in which the memory disturbance remained as a significant handicap in the years which followed the completion of therapy.

Although the immediate effect of treatment was almost uniformly satisfactory in the majority of cases, nevertheless there were some patients in whom the improvement was but slight or transitory. They did not gain sufficient well-being to be able to leave the hospital, or if they were permitted to go home on trial their relapses occurred quite quickly. We shall discuss these failures under the next heading.

FOLLOW-UP RESULTS

We have listed our subsequent results under three main headings. The first may be called failures, or unsuccessful results. The second may be considered as moderate improvement or social recovery. One might look upon these as partially successful. The third, and most significant group, are those who have shown substantial improvement. They comprise two subdivisions: (1) those who have remained consistently well over the six or seven-year period and (2) the sub-group of patients who developed recurrences which responded favorably to subsequent courses of treatment.

a. Unsuccessful results—failures.

Among the group of 100 patients were some 18 who are listed as failures. They include four whose response was so slight that they were unable to leave the hospital where they remained as chronic invalids. Three showed temporary improvement which lasted for a matter of weeks. A relapse developed shortly after the elation faded and the memory-clouding disappeared. Eleven included patients who had improved to some degree after a course of treatment. They were allowed home on trial and apparently made a fairly good adjustment for a period of months. However, these patients relapsed and further treatment failed to bring about recoveries. Thus, we list them as failures.

The larger number of unsuccessful cases were schizophrenics of long-standing. They were

chronic cases treated with a realization that not much was to be expected from treatment. More disappointing, however, were several more acute schizophrenic patients for whom recovery was expected. One was a striking young woman of 25 who had done fairly well with a course of insulin treatment in 1941 but who later relapsed. She was given electro-coma therapy with little improvement. She has had subsequent courses of insulin therapy and even a lobotomy in another city without significant betterment. A more common instance of failure is that of a hebephrenic young woman of 17 who had made a suicidal attempt with poison. She was given electro-coma therapy with some improvement. She was able to go home for several months, but quickly relapsed. Thereafter, additional electro-coma treatment did not achieve a major change. Insulin treatment was administered at the Cleveland State Hospital and likewise failed to alter the dismal course of the illness.

Not all the failures were schizophrenics. Several were in the involutional melancholia group. Such patients often showed temporary improvement with electro-coma therapy, but when treatment was discontinued the somatic delusions, the agitation, and fears recurred with intensity.

b. Partial improvement—moderately successful results.

Under the heading of partial improvement we have placed 17 patients. They showed sufficient progress after a course of treatment to leave the hospital and to resume their places in society. This group includes patients also who had made remarkable recoveries but who later showed recurrences requiring additional treatment. The second course of treatment, however, did not bring about more than a moderate improvement. A typical example of this group of patients is a Mrs. E. P., a woman of 50 who had resided in a sanitarium for about a year prior to her referral to us. During this period of hospital care and psychotherapy there had been little or no change. Indeed, she was referred for electro-coma therapy when it was found that she was contemplating suicide. She was treated in the summer of 1942 with considerable improvement. Gradually, however, her condition grew worse and she became once again depressed. Additional courses of treatment were therefore administered with but slight change for the better. She now lives at home, takes charge of some of her household duties, and is getting along well but at a lower level than her normal state. She lacks initiative, is troubled by insomnia and self-doubt.

There are several schizophrenics in this group who had been acutely disturbed at the time of the initial examination in the hospital. Treatment brought about definite improvement so that they were able to return home. Some of these patients are working and adjusting at a good social level. Nevertheless they retain some of their peculiar ideas and have not regained insight. For this reason we classify them as only partially improved.

c. Successful results but with recurrences and recoveries.

Recurrences were most frequent in the manic depressive psychoses. Yet even those cases whose symptoms were characteristic of schizophrenia sometimes gave a history of attacks prior to the time of treatment and developed additional symptoms some years after electro-coma therapy.

As is well known the frequency of recurrence and the number of attacks is a feature characteristic of each individual patient. For instance, Mrs. S. B. developed a recurrence one year following recovery from treatment and she had had additional episodes of depression practically every year thereafter. Indeed she has had cycles of melancholia from the age of 20 until the present (she is now 50) at approximately one year intervals. Another example is Mrs. H. L. who had gone through episodes of depression since 1935 at approximately 18-month intervals. She was given electro-coma therapy early in 1942 with improvement. However, in 1943 and again in 1945 and in 1947 she had additional attacks. In these two cases, outstanding in our series because of the number and rate of recurrences, symptoms developed spontaneously. We have compared the recurrences in manic depressive psychoses to the going off in the morning of an electric sign turned on and off by a biologic time switch wound by the fingers of destiny. In other cases a recurrence could be associated with a reappearance of a constellation of forces confronting the individual which he finds insurmountable. The illness represents an escape, a reaction to such overwhelming difficulties.

Recently, Saltzman[6] reported statistics on the subject of recurrences after-shock therapy implying that such treatment accelerated recurrence of symptoms. Our own experience contradicts the findings of Saltzman. Indeed we may offer a different explanation. Patients return earlier largely because of the remarkable benefits which they obtained from the previous electro-coma therapy treatment. We may offer the following example as an illustration. Mrs. O. E. had a moderately severe, though prolonged, depression in 1939. As she was close to 40 years of age she was given an extensive series of hormone injections. When this failed she went through an intensive course of psychotherapy to bring about improvement. This was followed by trips and a stay in rest homes, all without avail. In 1941 we gave her a brief series of electro-coma therapy. Conspicuous improvement resulted after four treatments in less than two weeks! This patient remained well until 1944 when she developed a recurrence. On this occasion she was brought by her husband for treatment within one month after the symptoms redeveloped and again got well with some four or five treatments. The resumption of treatment within a month rather than after a waiting period of two years might be statistically interpreted as a hastening of recurrence. Actually, a prompt readmission meant a shortening of suffering and a recognition of the remarkable benefit of electro-coma therapy.

Twenty-two patients had recurrences which responded to successful courses of additional treatment. One of our patients has had four series of such treatment. Fortunately they have improved with each additional series and have maintained well-being and good health during the intervals between the treatment. Although elation of moderate degree is common during and towards the end of a course of electro-coma therapy we have not observed any acute manic reaction as an alternating phase after a period of depression.

d. Sustained successful results.

Thirty-eight patients, the largest number in our series, are classified as recovered. We might term this the most successful result since these patients have maintained relatively good health for a period of six to seven years following the completion of treatment. This figure

when combined with the additional number of 22 means that 60 per cent of our patients have been relatively well for the entire period following electro-coma therapy.

We consider this as remarkably significant and we should like to mention briefly several illustrative cases. The first that comes to mind is that of a minister, aged 70, who had gone steadily downhill from a mild loss of confidence to a profound despondency so severe that he tried suicide through the gradual procedure of starvation. He was given some ten treatments in June of 1941 and has remained well up to the present time. When he last wrote to us he reported that he was back with his congregation, enjoying life and working as efficiently as ever. Neither his age nor his illness nor the treatments appear to have dulled his intellectual capacity. An even more dramatic recovery was that of Mrs. F. R. who was first seen by one of us in a mental hospital where she had been an inmate for five years. Treatment was undertaken after a discussion with the family to whom a dismal prognosis was expressed. Surprisingly she showed an excellent improvement at about the twelfth treatment and was given several additional reactions. This woman was able to leave the hospital and became reunited with her husband who had planned a divorce because she had been a long term institutional case. During the war years she and her husband moved several times; they faced many vicissitudes but she remained well. I use the term "well" to denote an individual not only possessing insight but retaining his or her usual intellectual resources and interest; one possessed of a normal emotional response. This patient has written many interesting letters, has visited with her friends, has worked actively.

Another strikingly successful case was that of F. M. who had been considered a rather hopeless schizophrenic and was confined to the isolation wards of a mental hospital. When the family asked for electro-coma treatment the psychiatrists previously in charge of her case were rightly skeptical of a method then relatively new. We all agreed on the poor prognosis in this case. Nevertheless after 25 treatments she responded very well. This patient has been out of the hospital for over six years working steadily and apparently enjoying good health. Numerous other examples could be offered. The majority of those who have enjoyed sustained recovery were depressed patients, mid-life depressions. Yet there have been a few instances of schizophrenia including the paranoid type. As an example may we mention the case of R. I. who was withdrawn, hallucinated, had delusions both of grandeur and of persecution. He received electro-coma therapy in June of 1941 and made a splendid, immediate recovery. He returned home in the summer of 1941 and was able to resume work shortly thereafter. He remained mentally well for the subsequent six-and-a-half-year period until he developed carcinoma from which he died in January of 1948.

e. Correlation of nature of illness with long term results.

Factors that influence the long term result are many: the number of treatments, the associated psychotherapy, the duration of the illness and especially the nature of the mental disorder. Insufficient treatment is an invitation to relapse while an adequate course with necessary maintenance doses will tend to prolong recovery. Psychotherapy directed towards providing insight and removing threats to security is also helpful. Duration of the illness is important, particularly as regards early recovery in schizophrenia. With electro-coma therapy as with insulin, chronic cases are less likely to do well. The most important single item is the nature of the mental disorder. Depressions as a group do well. Schizophrenics are less apt to show a long term recovery.

In mentioning the significance of the disease itself it must be stressed that one should not be too rigid in the interpretation. First there are often divergent views as to the diagnosis on the part of different observers. Likewise although a disease may in cross section have features of schizophrenia, the longitudinal study reveals the cyclic and favorable tendencies of an affect disorder. Then, too, it is not always a matter of all or none, schizophrenia versus manic-depressive psychosis, but there may be combinations.

With an appreciation that the present diagnostic categories should not be too rigidly respected, we will mention our figures. Of 54 patients diagnosed manic-depressives, 25 had sustained recoveries, 16 satisfactory results but with recurrences successfully treated, 7 moderately successfully and 6 failures. For the schizophrenics, 7 were successful, 6 moderately improved, and 9 failures. Thus the likelihood of sustained improvement is considerably greater in depression than in schizophrenia. However, this is an over-all group experience with many exceptions for individual patients.

MISCELLANEOUS OBSERVATIONS

a. Safety of electro-coma therapy—no deaths: There were no deaths in our series of patients during the course of treatment or immediately thereafter. Four of the 100 patients have died during the six to seven-year period, two of heart disease and two of carcinoma. There was obviously no correlation between the deaths and the treatment.

b. The problem of post-treatment spells: Not one of our patients has had epileptic attacks.

c. Worsening of the psychosis or marked change in the psychotic picture: In the original report in 1942 we mentioned the occurrence of three cases of acute toxic reaction or confusional syndromes. These three patients all cleared up and made good recoveries. This is the only type of worsening of symptoms during treatment which we have encountered.

d. The problem of back complications: Some years ago attention was focused on the complication of compression fracture as a serious disability occurring during treatment. We have mentioned that two of our patients had obvious, severe vertebral compressions, and that no doubt others may have sustained similar though milder forms of the same complication. We are not aware of any instance of subsequent deformity of posture or any serious disability related to back disorder. Our studies have not shown any neurologic complications from this bone in-

jury. Muscular soreness is fairly common during treatment but clears up after treatment is over.

e. The question of mental deterioration or irreversible brain injury: The report on shock therapy by the Group for the Advancement of Psychiatry[7] recommends long-term follow-up studies and implies fear about possible irreversible brain damage. We regret that our clinical study and the economy of time did not make it possible to carry out a consistent series of psychological and electroencephalographic investigations which were begun in our earlier work. However, this lack is offset by the close contact and the opportunity to observe the life activities of many of our patients. Indeed one may accept the test of the trials of life as a more complete search of a patient's intelligence than any standardized laboratory procedure. He who is able to contend with the challenges of everyday living and especially if he is able not only to maintain his career but to show advances is usually free of deterioration.

Our results do not show evidence of irreversible brain damage. Of course, we cannot be too positive about all of the eighteen patients who failed to improve and some of whom are now residents of a state hospital. Yet we realize that many had been, prior to treatment, serious hebephrenic, or paranoid schizophrenic patients already dissociated from reality We could hardly attribute their presence in the state hospital as different from a control group of similar patients studied during the pre-shock era who have spent years in such hospitals. More assuredly we can speak with some confidence of that larger group of 60 patients who have maintained consistent recovery even after a recurrence. Along with the successful group are the seventeen patients who have shown but moderate improvement and are free of deterioration.

We have personally known and observed and checked the work achievement and social status of most of these patients. We are able to report that they have been maintaining their roles as housewives, salesmen, mechanics, merchants, lawyers, and doctors. Perhaps the following brief case histories will illustrate the freedom of mental difficulties.

CASE REPORTS

There comes to mind the case history of a prominent attorney who was given a course of electro-coma therapy in 1941. Since that date he has been a leader at the bar trying cases that involve intricate technical details and participating in matters of profound legal and social significance. He has conducted himself with conspicuous success in his endeavors.

A woman in the early forties had gotten splendid improvement initially but has required several additional courses of treatment. We have seen her frequently, a charming and brilliant hostess, a successful business woman.

The minister whose case history was cited above is leading his church though he is in the early seventies. Mrs. F R. is a successful housewife seven years after a course of treatment. Another patient works in the science field and has established a unique reputation as a writer. Then there is a professional woman who during the war took charge of a major civic undertaking and who has subsequently risen step by step in her profession.

Even those who have shown but moderate improvement and are listed in the group of partial recoveries are known to us and have exhibited reasonably normal intelligence and capacity.

Our results thus confirm the observations of more recent students in this field to the effect that whatever damage is done is reversible.[8, 9, 10, 11] Memory tests show a quick return to normal after treatment is over and the electroencephalographic changes are but temporary. We may mention here the case report by Perlson[12] of the patient who had received 248 shock treatments yet whose intelligence tests later were found to be normal.

A COMPARISON OF PRESENT METHODS WITH THOSE USED IN 1941-42

The basic procedure of electro-coma therapy has remained the same, but there have been refinements of technique and modifications in the method which constitute major advances.[13] A few of these will be mentioned briefly.

APPARATUS

Several changes have been incorporated in the newer electro-coma therapy machine. One is the Wilcox-Reiter[14] apparatus which uses a uni-directional current. The other is the brief stimulus therapy technique introduced by Liberson[15, 16] and Goldman.[17] These modifications make it possible to produce the usual coma-convulsive response with a smaller dosage of electricity. The benefit of such technique is that it has reduced clouding of memory. More significant in our experience is the placement of electrodes. We have for several years placed one electrode on the vertex and another on the temple instead of using the previous bi-temporal application. This placement likewise reduces the quantity of electrical current. We had occasion to compare the disturbance in memory from the vertex-temporal with the bi-temporal placement and have found that the memory has been spared to a considerable degree. Another modification introduced by Tietz[18] and by Goldman has been referred to as glissando principle. The electrical current is raised gradually so that there is a sliding into rather than a jolt into

the convulsive response. It is hoped that this new principle may reduce traumatic complications.

PRE-TREATMENT PROCEDURES

We have for several years permitted our patients to take nourishment up to an hour before treatment. This alleviates discomfort of hunger and dryness of the mouth and lips which was so common in our earlier treatment group. We also employ sodium amytal intravenously, 3-3/4 to 7-1/2 grains, for apprehensive patients. Such a sedative not only reduces the tenseness before treatment but serves to reduce the tendency to post-treatment over-activity, and it helps to make the return to consciousness more gradual and more natural.

We have used "Intocostrin"[19] particularly in the strongly-muscled patients and in those who have sustained back injury or have developed severe back pain.

AMBULATORY TREATMENT

Our experience over a period of from 1944-1948[20] has demonstrated unquestionably the value of ambulatory electro-coma therapy. This makes possible treatment with an economy of time, of bed-space, of money, and of prestige. Our experience contradicts the pronouncement of report number one by the Group for the Advancement of Psychiatry that "electro-shock therapy be restricted to hospitalized patients. . . . We are opposed to the use of shock therapy in the private office because of its indiscriminate use." Every honorable physician deplores abuses of any procedure. But abuse of a method of treatment, be it psychoanalysis, surgery, or electro-coma therapy is chargeable to the man and not the method. We would emphasize the desirability of a sincere psychiatrist, well-trained in electro-coma therapy, skilled and eager to help the patient, and not emphasize the need of a hospital atmosphere or hospital buildings. We would agree with an attitude of conservatism and with emphasis upon the realization that electro-coma therapy is a procedure which should be delicately handled. Electro-coma therapy is a technique which improperly used can do harm; while carefully applied in the selected cases it does a tremendous amount of good. Consequently we would speak against the casual, disinterested, and inexperienced experimenter with shock therapy—and not make a distinction on where the treatment is given.

Our results in the ambulatory group have been as favorable as in those hospitalized. We agree with the statement of Impastato, et al.,[21] based upon a comparative study of hospital and privately treated patients. "Privately treated ambulatory patients seemed to respond better to electric-fit therapy than did clinic patients and hospital residents."

There are considerable advantages for the patient who can qualify for ambulatory electro-coma therapy who might otherwise have had to be hospitalized for treatment. First is a considerable saving in over-all expense. Whatever stigma the patient or his family might have felt is nearly entirely removed. Treatment can be instituted immediately and does not hang fire waiting for beds. Lastly, an ambulatory set-up facilitates the use of maintenance doses which are valuable in preventing relapses.

MAINTENANCE DOSES

In our earlier experience we encountered a considerable number of relapses. Though these occurred largely because of the inherent nature of the illness yet some relapses were caused by insufficient treatment. We discharged people fairly early because of economic reasons and the need for beds. A relapse would occur and it might take weeks or months before additional hospital care could be arranged. Today it is our practice to follow every patient discharged from the hospital in the office for observation and psychotherapy. If we detect any downward change in the patient's condition then additional maintenance doses are given. This has tended to increase the recovery rate and to reduce the number of relapses. Kerman,[22, 23] Moore,[24] and Kalinowsky and Hoch[2] have reported the value of maintenance doses on an extramural basis in reducing relapses and in maintaining reasonable adjustment of chronic patients who did not make complete recoveries. We are heartily in favor of the use of maintenance doses which are best given on an ambulatory basis.

PSYCHOTHERAPY

It is self-evident that electro-coma therapy is but a part of treatment, albeit a very significant item, and that psychotherapy should go along with it. There are many cases, particularly those with manic-depressive psychoses and the involutional malancholias in whom the physical effect of the current changes introspection into appreciation of external reality, sadness into cheerfulness, anxiety into confidence. These patients then minimize the problems which overwhelm them or are able to cope with them adequately. They require little outside guidance beyond the treatment itself. However, there are others who are beset with internal conflict and confronted with external situations which they are unable to master or to adjust to. Psychotherapy facilitates recovery and adds to the return of well-being.[25] It is our practice at present to arrange for psychotherapeutic interviews on days between electro-coma therapy treatments as well as for brief psychotherapeutic sessions at the time of treatment. Electro-coma

therapy is a major part of a combined operation rather than an exclusive method by itself.

COMMENT

As we view the long-term results of electro-coma therapy over a span of some six or seven years we ask ourselves if there is a direct correlation of lasting results with any particular feature of the patient, the therapist, method or number of treatments. Our figures do not permit a positive answer to these questions. As was mentioned above, the duration of recovery is correlated more closely with the nature of the malady than with any other specific feature. This opinion coincides largely with those of other observers. The results are connected also with the duration of the malady. Obviously the chronic schizophrenias have done worse than those that were fairly acute. All-important is the pre-psychotic personality of the patient in the end results.[26, 27, 28]

Results are not always predictable and one of the amazing impressions is the sustained recovery that certain schizophrenics have shown even though the predictions in such cases were unfavorable. The two cases which stand out most vividly are the patients F. M. and F. R. As was mentioned previously F. M. had been sick three years, was looked upon as a deteriorated schizophrenic and was confined to the isolation ward of the sanitarium. Mrs. F. R. had been in a mental hospital for five years. Both patients were treated early in 1941 and both have remained consistently well for a period of seven years. This experience justifies a trial of electro-coma therapy even in cases who on paper have a poor prognosis.

On the other hand we have been disappointed in the unfavorable results of certain patients who statistically were expected to get well. We already mentioned the patient with acute schizophrenia whose pre-psychotic personality was excellent and whose symptoms were fairly acute. This patient has remained a chronic invalid despite electro-coma therapy, insulin, and a lobotomy. Also there have been several cases of involutional melancholia in individuals previously fairly well but who have failed to respond to any degree to treatment. As yet we do not know why certain patients get well and certain others do not.

We recall quite vividly with what skepticism our colleagues, both psychiatrists and other physicians, looked upon electro-coma therapy. Yet we have seen the ever-widening use of this method by psychiatrists throughout the world and its appreciation by our professional brethren. It is significant that patients previously depressed who have undergone one course of treatment, are often eager to resume treatment when necessary. It is obvious, of course, that electro-coma therapy is not a cheerful experience and that patients approach such treatment often with uneasiness, trepidation, and doubt. Such fears can be greatly helped by the attitude of the therapist, his staff, and by the use of group psychotherapy. It has been our custom in ambulatory cases to surround a new patient about to get the first treatment (and his family) with several patients who are well on the road to recovery or those who have returned for follow-up and might be called alumni. It is heartening to see the enthusiasm which these improving and improved patients give to those who approach electro-coma therapy with anxiety and doubt.

CONCLUSION

This paper reports a follow-up study of one hundred private psychotic patients treated with electro-coma therapy in 1941-1942.

The immediate and early results of electro-coma therapy were uniformly good in a high percentage of cases.

Eighteen patients, chiefly schizophrenics and some with involutional melancholia, did not progress to full recovery or relapsed soon after the initial improvement. Some were quite well for a period of months or several years and then later developed regression. This group is considered as failures. However, many of these failures represent chronic patients who were treated with a full realization of the doubtful outcome only at the request of an insistent family.

Several chronic schizophrenics have improved with electro-coma therapy and have maintained apparently normal health over a period of seven years.

Eighteen patients showed partial improvement. They have maintained a fairly satisfactory social and industrial status.

Sixty patients showed a successful response to electro-coma therapy. Thirty-eight of this group have maintained well-being for the entire period of six to seven years. Twenty-two improved, then developed recurrences at a later date which fortunately cleared up with additional courses of treatment. The successful cases consisted largely of depressed patients and several manics. However, there were several schizophrenics among them.

There were no instances of epilepsy or death as a complication of electro-coma therapy.

In the large group of patients who were closely followed over a period of years, we have not encountered any instances of mental deterioration. Indeed, the sixty patients who are grouped as successfully treated consist of men and women in all walks of life who are maintaining or advancing in their jobs, careers, and in their social living.

The present technique is considerably improved over that which we employed in 1941

and 1942. The improvements consist of pre-treatment medication, smaller doses of electricity, and particularly ambulatory electro-coma therapy.

An extensive experience during the recent three years as well as in 1941 and 1942 heartily endorses the value of ambulatory electro-coma therapy. We stress the importance of a sincere psychiatrist, trained in electro-coma therapy, rather than the need of hospital walls and hospital atmosphere in preventing abuses. The man is more significant than the masonry.

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KEEPING UP WITH MEDICINE

• SCIENTIFIC evidence that white flour treated with nitrogen trichlorida is a source of epilepsy in dogs and certain other experimental animals, raises the question of what the wide-spread eating of this type of white bread has done to our citizens. They are now recommending that another bleaching agent be used.

* * *

• THE New York State nutrition survey indicates that there were food deficiencies of considerable magnitude in the 1,567 pregnant women surveyed.

* * *

• A DEFICIENCY of the amino-acid tryptophan in the diet resulted in the superficial growth of blood vessels in the cornea and a loss of fur on the eyelids of white rats with swelling and congestion.

* * *

• DR. TULIPAN of New York reports successful treatment of 96 patients with acne rosacea over an eight-year period by the use of the vitamin B-complex. This seems to be the real immediate cause.

* * *

• SODA added to tomato juice in the amounts usually recommended for making soups does cause a loss of vitamin C.

* * *

• HEN'S eggs are devoid of Vitamin C.

* * *

• SMOKING should be forbidden in all of those cases in which inflammation of the gums is accompanied with ulcerations of the membranes.

* * *

• IN RHEUMATIC disease, pain is nearly always of the deep variety.

* * *

• IF VACCINES are to be used in rheumatoid arthritis the dose must always be less than that required to produce a systemic reaction.

* * *

• IT HAS been shown that about 15 per cent of all women are Rh-negative but that only about two-thirds of these (10 per cent of all women) are married to Rh-positive men and bearing Rh-positive children. Erythroblastosis occurs in only .5 to .8 per cent of all pregnancies, or the children of only one in 25 to 30 Rh-negative women.

* * *

• THE incidence of asthma, hay fever, urticaria, and angioneurotic edema in gouty patients and their families has not been accurately determined in any large series of cases. Nevertheless there are many well authenticated instances where the eating of a specific food would produce an attack. Meat and fish have been the usual offenders.—J. F.

Some Phases of Postoperative Care in Gallbladder Surgery

GORDON G. NELSON, M. D.

THE textbooks and periodicals are replete with measures to safeguard the patient undergoing surgery of the biliary tract. Probably in no other field of general surgery, does the smooth postoperative convalescence depend on the proper preoperative and postoperative management, than in gallbladder surgery. Since this discussion is limited to actual postoperative care of patients who have undergone surgery involving the biliary tract, we will assume that the patient has had proper preoperative preparation, i. e., diagnosis, laboratory work and all the necessary procedures to insure that the patient will be in the best possible condition for surgery. Therefore, I will go over some of the problems and the way we handle them in our hospitals. These problems I have gone over just as they have occurred to me.

The Author

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ANESTHETIC

First, I think we must consider the question of anesthesia. The choice of anesthesia is important because patients with gallbladder disease have varying degrees of liver damage, and it is important to prevent further damage. We have found cyclopropane anesthesia supplemented with curare to be quite satisfactory. Relaxation is complete and the induction is quick and the postoperative recovery period is just as fast. In addition, we also at times use intercostal block, particularly in poor risk cases, together with light analgesia. Chloroform, avertin and ether are not good in biliary tract surgery, as they probably add to the operative danger.

Our next concern is the type of incision. Until about ten years ago, the upper right rectus incision was quite generally employed in gallbladder surgery. Since that time, we have been using an upper right oblique or transverse incision. Fraser Gurd has done a great deal to popularize this type of incision. It has been found that there are several advantages to this incision over the other type.

In the first place, there is a definite difference in the amount of pull exerted vertically by the recti muscles as compared to the lateral pull of the transversalis muscle, which roughly amounts to three times the pull of the former. One can readily see that it lends itself to good exposure and easy closure. In addition, retraction is kept at a minimum, which is important as far as healing is concerned. Exposure, as I have mentioned, is excellent, especially where the common duct must be explored. Also, it seems that postoperative complications are held to a minimum. Some years ago, in cooperation with our roentgenologist, a number of cholecystectomized patients who had upper right rectus incisions were X-rayed postoperatively, and it was found that in each case there was some elevation of the diaphragm and variable degrees of infiltration in the bases of the right lung. Since using the oblique or transverse incision, similar X-ray studies have shown less elevation of the diaphragm and considerably less infiltration in the overlying lung. Certainly, the incidence of postoperative atelectasis has decreased to almost nothing. I can remember the time when our bronchoscopist was called on too frequently to aspirate the thick tenacious secretion blocking the bronchus. I might add here that early ambulation is carried out with less discomfort to the patient if he has an oblique or transverse incision.

IMMEDIATE POSTOPERATIVE CARE

Immediately postoperatively, the most important thing we have to think about is the amount and character of fluids the patient must have. We know that the average daily water intake of a normal adult is about 3000 cc. made up as follows: water and other beverages 1200 cc., water of solid food 1500 cc., water of oxidation, which amounts to about 12 cc. per 100 calories or 300 cc. The average daily output is about 3000 cc. consisting of 1500 cc. urine, 200 cc. feces, 300 cc. perspiration, insensible water loss from skin 700 cc., and from the lungs 300 cc. It is obvious that an attempt should be made to give the patient this much during each twenty-four hours postoperatively. During operation the patient receives 5 per cent glucose in saline intravenously or blood or both. It should be

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emphasized that blood should be available in all cases, especially where there is jaundice or disturbance of the clotting mechanism of the blood. Our hospitals are fortunate in having blood banks from which blood and plasma are instantly available.

SALT

Coller and Maddock have pointed out the importance of maintaining the sodium chloride and dextrose requirements of the body in surgery of the intestinal and biliary tracts. They point out that attention must be paid not only to the quantity but the kind of fluid necessary. Dextrose and sodium chloride are probably the two most important fluids necessary for the body, postoperatively, with the exception of blood or plasma. For several years it has been emphasized that there is danger in the use of large amounts of saline solution. The normal sodium chloride intake is 3 to 10 grams a day, but a healthy normal individual may tolerate as much as 35 to 40 grams daily without apparent difficulty, as the kidneys are able to excrete salt in the urine in concentrations up to 2 per cent. The postoperative patient is not, for the time being, a normal individual, and has been pointed out by Ravdin and associates, in the presence of renal or hepatic damage or serious sepsis, the greater the degree or severity of these conditions, the less salt solution does it take to produce edema.

Where losses of sodium chloride are not abnormal, then the amount of salt solution should not exceed 1000 cc. daily (9 grams of sodium choloride) which is about the normal daily intake. This, of course, should be increased if there is constant suction drainage, biliary or intestinal drainage or persistent vomiting, and the amount given should be based on the amount lost. Bartlett and his co-workers have developed a clinical rule which can be used when it is not possible to measure accurately the amount of fluid lost. The plasma chloride level should be determined and "for each 100 mg. that the plasma chloride level needs to be raised to reach the normal (560 mg. per cent) the patient should be given 0.5 gm. salt per kilogram of body weight."

The estimation of the urinary chlorides will tell if enough or too much saline is being given, for as long as the patient excretes 1 gram of salt per day in the urine there is little danger of salt depletion. Dextrose in distilled water, usually in a solution of 5 per cent, supplies water for vaporization and urine formation, and also makes available a supply of carbohydrates for energy requirements, for glycogen formation, and for oxidation of ketone acids if they are present. If the need for satisfying the above requirements is urgent, a 10 per cent solution of dextrose may be given. Winslow states that about 98 per cent of a 5 per cent solution of dextrose in distilled water was utilized when administered intravenously at a rate of 300 to 500 cc. per hour, averaging 1.35 gm. of dextrose per kg. of body weight per hour. He found also that 95 per cent of the dextrose of a 10 per cent solution given at the same rate was utilized. It has been recommended that a rate of 200 to 300 cc. per hour be used in the administration of the 10 per cent solution if the best utilization is to be secured. However, I believe we give our dextrose more rapidly than that.

AMINO ACIDS

In recent years the use of amino acids parenterally has become quite general. We have used it considerably in the preparation of patients undergoing surgery of the biliary tract. There are a few reactions which should be noted. It is well known that nausea with or without vomiting, fever with or without chills, abdominal pain, and a tendency to phlebothrombosis, occur in about 4 per cent of patients receiving amino acid preparations. The cause of these reactions is said to be due to rapid administration of the solution. Several deaths have been reported as being directly due to the administration of intravenous amino acids. I have one case, that of a man who was being prepared for gastric surgery. A few moments after the beginning of the amino acid administration, the patient complained bitterly of substernal pain, and broke into a cold sweat. His blood pressure dropped sharply, the pulse became weak and thready. The needle was immediately removed, an electrocardiogram taken, but no evidence of cardiac disturbance noticed. In a short time the patient was perfectly all right and underwent his operation a few days later without mishap. We have found that patients who are to receive amino acids parenterally are less prone to reactions if they have been given glucose intravenously a few hours before.

FEEDING

This brings us up to the idea of feeding patients shortly after operations, particularly after a cholecystectomy. Through the years, the advancement of anesthesiology and the ever widening margin of safety in this field, have produced a gradual elimination or reduction of the unpleasant stage immediately after operation. With the newer types of inhalation anesthesia, there certainly is less tendency to postoperative nausea and vomiting, and sometimes none at all. It has been our policy to start feeding these patients early after operation, except, of course, the patients with gastric resections. Within five or six hours after operation, we allow the patient to take dry toast with jelly, tea, thin cereal with skim milk, cooked fruits, etc. He

is encouraged to chew the food even if he doesn't care to swallow it. It has been our experience that most patients can do this, once the idea has been explained to them. The diet can be expanded quite rapidly after that, with special stress on the carbohydrates and proteins. This does several things: the act of chewing encourages the emptying of the salivary glands and stimulates the flow of saliva, and thus prevents the occurrence of surgical parotitis. Since we have instituted the early feeding of patients we have not had a single case of that dreaded complication. Prior to this, I believe we had to deal with surgical mumps about once or twice a year, and that is too often to suit me. In addition, we have found that patients who can take some food during the early hours postoperatively are bothered less with gas, and normal elimination is more easily established. I can truthfully say that many of our cholecystectomized patients have never missed a meal.

EARLY AMBULATION

Many reports in the literature are found of late on the use of early ambulation following major surgery, and we think it is one of the best ideas that has appeared. The idea is not new by any means, but it is only in the last eight or ten years that it has become generally accepted. The earliest reported case was the one by Ephraim McDowell in 1809 who stated the case of a woman on whom he had performed an ovariotomy. She got up against his orders, and he found her making her bed when he visited her on the fifth day. Dr. Leithauser of Detroit reviewed the literature, and found that Rees in 1899 routinely allowed his patients to arise early. Between 1920 and 1930 many reports came from foreign countries and a total of 15,000 cases of early ambulation were reported. Among these, Zava reports 6,000 cases without eventration or embolism. Prolonged bed rest, I suppose, is traditional, and probably the result of certain fixed ideas. First, it has generally been supposed that wounds heal more rapidly when the patient is immobilized, and does not tear and pull at the sutures through exertion. Also, it is believed that the resting patient conserves his energies and allows his body to rebuild its tissues from injuries received through operation and previous illness. Lastly, pulmonary emboli, which supposedly form on the third day, have time to dissolve during the long period of bed rest.

The advocates of early ambulation believe that the value of prolonged bed rest during convalescence is overestimated and may be detrimental to the well-being of the patient; that wound healing is actually retarded when circulation is slowed through inactivity. Kimbarovsky immobilized a group of dogs in plaster casts after operation and allowed another group of operated dogs to move about freely. He found the tensile strength of the wounds greater among those that moved about unrestrained. The tensile strength of absorbable suture is greatest immediately after operation and gradually decreases until about the fifth day when it is supposed to be the weakest. Therefore, if these patients are to be allowed up early, it should be during the first twenty-four hours. Our patients are allowed up to void during the first twenty-four hours and also encouraged to breathe deeply every few minutes.

During the war, early ambulation proved to be a boone to overcrowded and understaffed hospitals. Bedridden patients simply could not be given the care they needed. It was found that most patients can help themselves if only encouraged to do so, and they can overcome the almost inborn fear of doing some harm to themselves by unrestrained motion. We have found that since instituting the practice of early feeding and early ambulation, the incidence of surgical parotitis, pulmonary embolism, and phlebothrombosis has dropped to practically zero. In addition, the patients are quite enthusiastic and seem to be much better during the later postoperative days. They also can leave the hospital much earlier, which makes a considerable saving.

STONE IN COMMON DUCT

Finally, I would like to mention one condition which bothers us, and that is the occasional case in which a stone is left behind in the common duct. It is our custom, in all cases of T-tube drainage of the common duct, to have a cholangiogram made by instilling lipiodol into the T-tube. This will demonstrate if a block exists and if it is due to stone, edema or spasm of the sphincter. In 1938, Dr. Best advanced a technique for the removal of remaining common duct stones. It extends over a three-day period. On the first day, gr. 1/100 of nitroglycerine is given three times. On the second day, atropine gr. 1/100 (oral or hypo) is given three times. On the third day, the nitroglycerine is repeated. Each morning the patient is given mag. sulphate drams 2 in warm water and at bedtime olive oil ounces one. The common duct is gently irrigated every day through the T-tube with warm normal saline solution. Remove the solution with the syringe. Five minutes later, instill 10 to 30 cc. of warm sterile olive oil. If the patient does not complain of distress, the tube should be clamped off during the course of the treatment except for one hour after instillation of the oil.

If there is no liver damage, the patient is given decholon or procholon 3 to 5 tablets gr. 3-3/4 four times daily to increase and maintain pressure within the common duct. The treatment may be repeated after one day rest and

may be given ten times during a two-month period.

In 1946, Harris and Marcus used a plan suggested by Rabinowitz. The idea is based on the fact that the presence of a stone in the duct causes a reflex spasm of the sphincters of Boyden and Oddi. There has also been noted the production of traumatic cholangitis with mucosal edema, both of which tend to grasp the stone more firmly and to maintain the obstruction. This spastic reflex can be arrested by the instillation of nupercaine in a concentration of 1:1000 to 1:500. We have tried this on occasion and found the results to be good. I would like to report one case in which this was tried with very good effect.

REPORT OF A CASE

A fifty-nine year old woman had had her gallbladder removed eighteen years previously, and about two months prior to her present illness began with episodes of pain in the epigastrium and vomiting, with jaundice of a mild character. At operation, a dilated common duct with a number of stones was found. These were removed, and T-tube drainage instituted. Postoperative convalescence was quite uneventful until the tenth day, at which time she began vomiting and having pain in the epigastrium. She also started to have acholic stools. The cholangiogram showed a complete block at the outlet of the common duct with a concave shadow which was interpreted as a stone lodged in the sphincter. The Best regime was started, and nupercaine solution was used as outlined by Rabinowitz, and at the end of the three-day period, the pain and vomiting ceased, and the stools became of normal color. Unfortunately the T-tube was expelled spontaneously, before another cholangiogram could be made, but the immediate clinical improvement was so striking that it was obvious the stone had become dislodged and was passed on.

CONCLUSION

In conclusion, I have tried to bring out some of the problems which we have in our approach to the postoperative care of patients undergoing surgery of the biliary tract.

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Cyanosis in Infants from Polluted Well Water

The discovery that well water, even though boiled, may be toxic for young infants was first made by Comly in 1945. He reported two cases of his own and nineteen observed by others in whom the ingestion of polluted well water caused cyanosis and listlessness. In his first case the cyanosis had previously been shown to be due to methemoglobinemia; a peculiar gaseous poison arising from a defective oil burner was suspected. Comly's contribution consisted in showing that the methemoglobinemia was due to the use in the formula of well water which contained 619 mg. per liter of nitrate ion.

The November, 1946, issue of the *Journal of Pediatrics* contains two articles reporting further instances of cyanosis in infants from the use of well water in their formulae. One article is by Ferrant of Louvain, Belgium, and the other by Faucett and Miller, of Kansas City.

Methemoglobin is a changed form of hemoglobin in which the capacity for transporting oxygen to the tissues is blocked by an OH group. This chemical change is brought about in many different ways; poisoning with aniline, nitrophenol, sulfanilamide, potassium chlorate are all well known agents in its production. The ingestion of nitrates has also been known to produce methemoglobinemia. The nitrate is apparently reduced to nitrite in the bowel and is absorbed in this form. Cyanosis has followed the use of bismuth subnitrate in the treatment of diarrhea or as a contrast medium in gastrointestinal radiology. Ferrant calculates that the quantity of nitrate ion ingested in reported cases of poisoning from bismuth subnitrate is of the same order of magnitude as the nitrate ion ingested in the reported cases of cyanosis from well water.

Ordinary clinical cyanosis such as one sees in cardiac and pulmonary disease is due to the presence of reduced hemoglobin in the circulating blood. If the disease is such that it permits the administration of high concentrations of oxygens the latter corrects the cyanosis. In contrast, the cyanosis due to methemoglobin is not improved by oxygen, and, as Comly states, it gives the skin an unusual brown-gray color, noticeably different from the color of reduced hemoglobin. Everyone is familiar with the cherry red color of the lips in asphyxiation with carbon monoxide; this is the color of still another form of hemoglobin—carboxyhemoglobin. In the seven cases of cyanosis from well water which were personally studied by the three authors quoted, the ages of the infants ranged from two to six weeks.—Edwin A. Harper, M .D., Lynchburg, Va.; Virginia Medical Monthly, Vol. 76, No. 1, January, 1949.

Cosmetic Sensitivity

HARLEY A. HAYNES, JR., M.D.

A COSMETIC is a preparation intended to embellish or beautify the skin, hair or complexion; in other words, to make the individual look prettier and smell sweeter. For practical purposes, a cosmetic can be considered as a preparation to be used externally to add to or camouflage skin texture, color, and odor. The best and most satisfactory cosmetic preparations fulfill these requirements; do not materially benefit the person's anatomy or physiology, but neither do they irritate. In spite of the greatest care in the preparation and manufacture of cosmetics and selection of the ingredients, occasionally irritation of the skin is produced by some product. This irritation, or inflammation of the skin occurs where the offending cosmetic is applied; in other words, it is a contact dermatitis.

Rather than limit this discussion to sensitivities produced by cosmetics, I would prefer to give a few generalized considerations to the broad subject of irritations caused by external contacts, because they are one of the commonest types of skin disorders encountered.

Contact dermatitis is a reaction of the skin due to an external noxious agent, the reaction usually limited in area to the site of application or contact of the offending agent. The reaction consists of varying degrees of redness, swelling, blistering, scaling, and at times, even localized destruction of the skin. These manifestations are accompanied by burning, itching or pain. In addition to producing a local effect at the site of contact, occasionally reactions of the skin may occur in more extensive areas. With some substances, absorption may occur and systemic toxicity, and even death, ensue. The irritating agents may be gaseous, such as the war gases, liquid or solid. So many types of external irritants exist that the possibility of contact dermatitis, its recognition and its prevention are problems in every field of our daily life. The hazard may arise from the contact with poison ivy during a walk in the woods; from the many chemical products used in industry that result in contact dermatitis, which is the largest single disabling factor in industrial medicine; from household cleaning agents; or from the use of cosmetics.

PRODUCTION OF CONTACT DERMATITIS

The single constant factor necessary for the production of a contact dermatitis is the direct contact of whatever agent may be responsible with the skin surface. Following this contact with the responsible agent, the skin becomes reddened, swollen, itchy, and if the process is severe, blistering develops. If the reaction is mild but prolonged, scaling develops at the site of the irritating contact. The dermatitis usually appears in a space of several minutes to several days following the external irritation. Except for this one constant factor of contact with the skin by an external agent, the other factors necessary to produce a dermatitis are quite variable; such as concentration, exposure, sensitization, etc.

I. Exposure. Dermatitis due to contact may occur at the first exposure to a given agent, or may require repeated previous exposures before the individual becomes reactive to that agent. Typical examples of repeated contact being necessary to produce sensitivity, or altered reaction in the patient, are poison ivy and finger nail lacquer. It is considered that no infants react to poison ivy, or the noxious oleoresin contained in it, but that after repeated exposure to the ivy plant, a time comes when the miserable, uncomfortable poison ivy dermatitis develops.

Women may wear nail lacquer for years with no reaction, and suddenly, with no change in the product that has been used, become sensitized and develop a skin irritation, which is usually limited to the eyelids and sides of the neck. Other products, such as mercurial compounds, may cause a reaction of the skin at first contact. The war gases likewise irritate at first exposure.

II. Primary irritants are considered to be those products which, upon contact with the skin, affect all, or at least an appreciable percentage of the individuals exposed. The war gases again are excellent examples of this type, as well as many of the industrial chemicals and solvents.

III. Sensitivity of individuals to external contacts can be considered an altered or abnormal reaction, the exact mechanism of which is not known. A substance which rarely affects most

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people may produce a violent reaction in a sensitive person. That sensitivity may at times seem to be inherent in that individual, and a reaction may occur on the first contact. However, sensitization is usually acquired through repeated previous exposures which did not produce any reaction.

IV. Concentration. The reactions of contact dermatitis depend not only on the specific contact agent, or qualitative factor, but also on the concentration, or quantitative factor. Increasing dilution of a primary irritant will result in a decreasing percentage of the individuals reacting to that noxious material. For example, a strong solution of phenol applied to the skin of test subjects will cause damage on all subjects. However, if the percentage of phenol is decreased for instance to one per cent and applied to the skin of a hundred test subjects, possibly only one individual would develop a reaction at the site of its application. That individual might be considered sensitive to this dilution of phenol.

V. The external agents eliciting a contact dermatitis are usually relatively simple chemical compounds, varying from the simplest inorganic, to more complex organic compounds, the formulae of which in general are known. An example of a simple inorganic compound frequently causing irritation would be ammoniated mercury; or simple organics, picric acid, on through paraphenylendiamine, and on up to the more complex.

VI. Desensitization. Ordinarily it is impossible to desensitize an individual to prevent his reaction to an external contact from which he has previously developed a dermatitis. Prevention of the reaction consists of avoidance of the specific contact, protection of the skin surface from that contact, occasionally chemical neutralization, or dilution.

VII. Unusual reactions. In addition to the common reactions of redness, swelling, blistering, several variations may occur, such as depigmentation of the skin at the site of the contact, or increased pigmentation. An anti-oxidant used in rubber compounds several years ago, the monobenzyl ether of hydroquinone, produced, in addition to the usual inflammation of the skin, a residual depigmentation, which persisted long after the inflammatory reaction had subsided. Oil of bergamot used as a fixative in perfumes may produce a pigmentation at the site of the dermatitis in sensitive individuals. A few compounds such as the brom-acids (tetrabromfluorescein) may require contact with the skin, plus ultraviolet light or exposure to the sunlight before reactions develop. A photo sensitivity, or dermatitis from sunlight, may then persist for some time after the contact with the brom-acid has been eliminated.

VIII. The satisfactory **recognition and removal** of the offending agent usually results in a prompt subsidance of the dermatitis and cure, with no scarring or residual abnormality of the skin. However, the embarrassment of the appearance and the discomfort during the siege of dermatitis may be the basis of a legal suit. In rare instances, however, a persisting eczematization may require treatment long after the original cause was removed, and localized infections sometimes occur due to scratching.

CONTACT SENSITIVITIES VERSUS ALLERGIES

Broadly speaking, contact dermatitis may be differentiated from the common concept of the usual allergy. The typical allergic individual has inherited his allergic background, and a family history of some type of allergic phenomenon can be obtained. This is not true in contact sensitivities. Furthermore, in contact dermatitis, contact with the skin must occur, and the skin reaction and inflammation is the distressing product. In allergies, the so-called allergen, or noxious agent, may be inhaled, eaten or injected, and the reaction of the allergic individual need not occur at the site of entry of the allergen, but may be manifested variously as hives, asthma, hay fever, cramps and diarrhea, sneezing, a true eczema of the skin surface, or swelling of the joints. As previously stated, the commoner causes of contact dermatitis are relatively simple chemical compounds; whereas in allergies, the usual allergens are complex proteins or protein derivatives. Other technical differences not seen in contact dermatitis but present in allergic reactions are antibodies in the blood, the possibility of passive transfer by serum to another individual, and the possibility at times of desensitizing an individual to a given allergen. Testing for allergens is done by scratch or intradermal injection.

A few drugs seem to bridge the gap between contact sensitivity and allergy. For instance, a patient may be intolerant to a sulfonamide drug by mouth, or develop an allergy to this drug after prolonged use, and later prove also to have developed a contact sensitivity, as evidenced by a local reaction on the skin at the sight of application of a sulfonamide ointment. Penicillin likewise may produce similar reactions, although they are not nearly as serious as reactions to the sulfonamides. Conversely, the application of sulfonamide ointment to the skin, and the production of a contact sensitization may make the patient intolerant to the subsequent oral administration of a sulfonamide.

IDENTIFICATION OF IRRITANTS

Having defined contact dermatitis and described its reactions, it would seem simple to make the proper diagnosis, find and eliminate

the offending contact agent, and thus cure the patient. Unfortunately, however, the identification and proof of the irritating contact at times requires the help of a Sherlock Holmes, plus the patience to be able to find a needle in a hay stack. By long experience, the site of the reaction may call to mind certain possible external contacts, and history from an intelligent patient may at times give a clue to the causative agent. Too often, in an unintelligent patient, the history of exposure to various cleaning compounds, cosmetics, etc., is so unreliable and muddled that the physician is in no better position than a veterinarian with a jackass.

If no clue to the identity of the offending agent can be obtained, relief can be achieved by hospitalizing the patient and removing him from all previous contacts such as home, clothing, furs, cleaning solutions, industrial contacts, and cosmetics. If a clue can be obtained, proof of the offending agent can be made by trial elimination; then following clearing, by intentional contact, to discover if the dermatitis reappears. Instead of intentional contacts, small amounts of the suspected irritant can be applied to the skin in the form of patch tests, so that if positive reactions are obtained, the areas of reaction will be small, and the inconvenience to the patient minimal.

PATCH TESTS

Patch tests may be applied with solids or ointments made from suspected compounds, usually over a postage stamp size area of the skin, surrounded and covered by paper, and affixed by adhesive tape. The patches are left on for forty-eight hours, unless discomfort and early reaction indicate their removal by the patient. The paper is applied over and around the application of the test substance to differentiate and leave a clear zone around the possible reaction, because approximately 20 per cent of the population develop a contact dermatitis to the adhesive tape with which the patch is applied. In the case of liquids, a small watch crystal can be filled with the test liquid and tightly applied to the skin, in order to maintain that liquid in its original concentration and to prevent loss by evaporation. The areas tested show a positive reaction varying from mild redness, to swelling and blistering.

Of course, in trying to determine the cause of a contact dermatitis by patch testing, one must have a fairly good idea of the possible external contacts to use as tests. Patch testing is not always successful and carries some hazard. A strongly positive reaction of a patch test on a clear area of the skin may result in a flare-up of an existing contact dermatitis, or may even cause a reactivation at the site of a former contact dermatitis which has completely subsided. In cases of a very mild contact dermatitis, manifest by minimal redness, scaling and itching, a patch test may show no reaction whatever, either because it may require much longer exposure than forty-eight hours, or need friction, heat or sweat to effect contact with dry substances, or the small area of the patch test is insufficient to produce a visible reaction. Another failure occurs with localized sensitivities. A typical example of this may be the scaling and redness of the eyelids where the skin is thin and tender. The lids may have developed a local sensitivity to the noxious element, e.g., nail lacquer, which does not always react in the skin elsewhere under a patch test.

The information gained from patch testing can be extremely valuable, both in determining the cause of reaction of an existing contact dermatitis, and as a method of determining whether new products may be noxious before their distribution to the public. In the presence of a contact dermatitis, history and elimination techniques will probably narrow down the possible responsible agents to a few materials which can be used as patch tests. A positive patch test, plus cure of the patient by elimination of this substance, may be considered as adequate proof that this particular substance was responsible. Having determined the offending compound, the specific irritant can then be found. For example, if the offending material appears to be cold cream, with the cooperation of the manufacturer the preparation can be broken down to its several ingredients and patch tests applied to determine which one of the ingredients may be responsible. It is always of interest, and probably of benefit to the manufacturer, to know the cause of difficulty with his product, so that possible changes in the formula can be made.

When patch testing with the ingredients of any preparation, cold cream or otherwise, the ingredients should be applied in the same dilution in which they exist in the product, and the ingredients are diluted with some relatively bland innocuous compatible agent. Perfume may be diluted in water, an alcoholic solution, or oil, colors in petrolatum, and usually solids, more or less inert, such as beeswax, applied as such. When these diluted ingredients are applied to the skin as patch tests, control patches must be applied with the diluent to make sure that a positive reaction is due to this specific ingredient, and not the diluting agent.

New products and new ingredients can be tested by applying both ingredients and finished products as patch tests on volunteer test subjects. If the original tests provoke no reactions, the test subjects should be re-tested after twelve days, to determine whether sensitivity has developed. Animal experimentation may reveal the toxicity of a given agent when either fed or injected in the animal, and may likewise be useful in test-

ing for the toxicity and absorption of certain external agents. However, because animal skin does not react in the same way that human skin does, and because blistering is almost impossible to provoke in animals' skin by an external irritant, animal experimentation is not a satisfactory proof that an external contact agent will not irritate the human skin.

COSMETIC IRRITATION

The ingredients of cosmetics which may provoke irritation may be divided into (1) primary irritants, (2) absorbable elements which result in systemic toxicity, (3) bland, ordinarily harmless ingredients to which a few sensitive patients react, and (4) ingredients which cause known sensitivity on repeated application. You will naturally assume that no cosmetic contains either a primary irritant, nor an absorbable toxic material. However, numerous cases of blindness and at least one death occurred due to the use of "Lash Lure," a dye to be applied to the eyelashes. (November 10, 1934, A. M. A.) This product consisted of an analine derivative, but did not contain paraphenylendiamine. Numerous cases of irritation of both the lids and eye proper occurred with subsequent permanent scarring of the eye and impairment of vision, and at least one death was reported due to absorption. In the April fifth issue, 1941, of the *Journal of the American Medical Association*, an accidental death was reported from the absorption of a heatless permanent wave solution, presumably ammonium hydrogen sulfide with non-volatile elements of free sulfur and ammonium sulfide. Death resulted within twenty-four hours following the application of this solution to the scalp. Needless to say, even animal experimentation could have revealed the toxicity of these products and prevented these catastrophes from occurring before their distribution and sale.

There are individuals who may be sensitive to any and all bland common products which are in general harmless to most of the population. Without exaggerating, it seems there may be people who are sensitive to everything except distilled water and air. Therefore, ordinarily innocuous ingredients in cosmetics, such as lanolin, petrolatum and beeswax, at times may cause reactions in certain people, and I can see no way in which these rare reactions can be avoided, although they can be minimized by using ingredients with no impurities. The fourth and largest group of cosmetic ingredients with which we are concerned in contact dermatitis are those materials which are either frequent sensitizers, or which produce eventual sensitization after prolonged use. Many of these ingredients can be eliminated from the manufacture of cosmetics. Others are still used, even though their sensitizing properties are known, because no adequate substitute is available, or because of the relatively low frequence of reaction to them. Examples of this type are the brom-acid dyes used in lipstick, some of the synthetic perfumes, and the impurity in nitrocellulose, which produces the reaction to finger nail lacquer.

The cosmetic industry, with the guidance of the Pure Food and Drug Administration, has done an excellent job of removing and eliminating potentially sensitizing and noxious ingredients from their products. At the present time, reactions to cosmetics seen by dermatologists are not too common, and few of them of a very serious nature. The cosmetic industry benefits as much as the user of cosmetics from this care in the manufacture of their products, both in good will and in advertising, and economically from lowered product insurance rates and fewer damage suits.

Cosmetic preparations may be classified in numerous manners, according to location where used, from a hair shampoo to a foot powder, and all intermediate locations, or to physical properties; such as emulsions (cold creams, vanishing creams), solutions (hair tonics, lotions), pastes (tooth, deodorant), powders (face, foot), sticks (lip, eyebrow pencil), jellies (wave set, brilliantine), cakes (rouge and powder), ointments (suntan, hair) or suspensions (face powder). However, I prefer in speaking of sensitivity to mention some of the ingredients which may cause reactions.

IRRITATING INGREDIENTS

The single most frequent offending ingredient of cosmetics is perfume, because it is common to all products. Perfumes are mixtures of vegetable and animal oils and synthetics. The vegetable oils include flower and fruit extractives; the animal products are usually fixatives, such as ambergris, civet, musk and castor. Numerous synthetic organics are now used because of availability and relative cheapness and are apt to be contact sensitizers. All of the essential oils have the property of becoming skin sensitizers, although oil of bergamot is probably the worst offender and also has the property in sensitive individuals to produce pigmentation of the skin following exposure to sun light.

In order of frequence, the next commonest reaction seen in patients applying for relief is due to nail lacquer, which usually causes dull redness and scaling of the lids and sides of the neck where a woman rubs her nails when adjusting the dress. The specific chemical causing the sensitization has not been isolated, but is presumed to be a formaldehyde resin as an impurity in the nitrocellulose. Little difference is seen in the frequence of reaction to clear nail lacquer from colored, and here, as in rouges, powders, eye shadow and lipstick, the aniline

lake colors may be stated to be infrequent irritants.

Lipstick dermatitis is manifested by swelling, scaling and occasional blistering of the lips and is usually due to the brom-acid dyes, although at times again perfume may be responsible, as well as rare reactions to petrolatum, castor oil or beeswax.

Hair dyes are relatively frequent irritants, and in spite of the recommendation on the label of most products that a patch test be applied before the dye is used, this precaution seems rarely to be followed by the beautician. The reactions to hair dyes include redness and weeping of the scalp, as well as a diffuse redness and swelling of the skin of the face and neck, particularly the lids, where the hair comes in contact with the skin at night. These reactions are not necessarily limited to the individual who submits to the hair dyeing. Several years ago I had a patient with repeated recurrences of contact dermatitis of the face, with swelling, redness and scaling of the eyelids. The patient was an elderly mortician, and the only contact history I could elicit was the possible recurrence of the dermatitis when arranging flowers for funerals. All patch tests with flowers and suspected contactants were negative, and the cause of the dermatitis went unrecognized for several months, until one day the patient's wife chanced to come in the office with him. She had obviously dyed her hair, a fact of which her husband was unaware. A patch test on the man's arm with a swatch of her dyed hair produced a severe reddened and blistered area, and cessation of the wife's hair dyeing treatments resulted in complete relief of her husband's dermatitis.

Hair dyes are in general of four types (1) the aniline derivatives and paraphenylendiamine being the most common because of flexibility of color range; (2) metallic salts, particularly lead, silver and bismuth chlorides, sulfides and acetates; (3) pyrogallic acid; and lastly (4) the vegetable dyes, which are infrequent offenders, but not too commonly used, such as camomile, henna, sage, walnut and nut galls.

The depilatories, such as the alkaline sulfides (barium, strontium, calcium and mercaptan carboxylic acid) may frequently cause irritation of the skin, because they are kerato-hyalin solvents, and inasmuch as the horny layer of the skin and hair are of the same chemical nature, chemical dissolving of the hair perforce tends to remove a portion of the protective layers of the skin surface. Thallium acetate has now been outlawed as a depilatory agent, because of its extreme toxicity. Thallium works through absorption, and may be given orally, and produces an indiscriminate falling of hair as well as a dangerous nephritis. Wax depilatories are as a rule only mechanically irritating.

Reactions to face powder are uncommon, and when they do occur, slowly develop as a diffuse scaling with slight redness and much itching of the face. Patch tests with powder are usually unsatisfactory and proof of the irritating factor can best be done by eliminating certain ingredients and then trying the powder again. Most of the reactions prove due to perfume. Orris root has not been used in American face powders for some time, and in general, did not cause many skin reactions, but was instead an allergic offender due to its inhalation. Most other products, such as cold cream, vanishing cream, body powder and lotions seem to be rare causes of irritation, except for their perfume content.

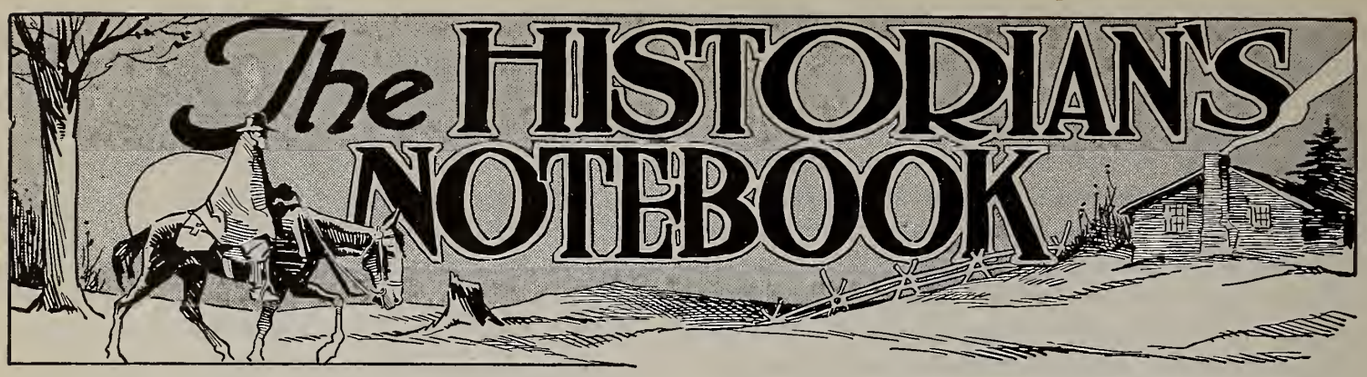
In addition to specific ingredients which are sensitizing agents, irritation frequently develops due to the non-specific factor of alkalinity. The normal pH of the skin is neutral to slightly acid (5.5 to 7.0). Because of their inherent chemical structure, soaps and vanishing creams are alkaline and at times are not well tolerated by patients, causing burning and dryness of the skin.

The so-called non-allergic or hypo-allergic cosmetic products have eliminated some of the common sensitizers, such as perfume and tetrabromfluorescein, at the expense of the pleasant cosmetic properties of the products.

I have not discussed the hormone creams, for certainly they don't fulfill the definition of a cosmetic of improving appearance, color or odor; nor as sold by cosmetic companies indiscriminately over the counter, can they be considered as a medication, because neither the dosage, usefulness, nor medical need of the product is considered. Furthermore, the addition of hormones in certain types of cancer, which, if early, may be unsuspected by the patient, may be extremely dangerous, causing an increased rate of growth of the cancer.

ADDENDUM

Recent products known as nail undercoat, or sometimes referred to as an adherent or base coat, have caused some difficulty. These preparations were to be applied to the nails before the application of nail lacquer, the purpose being to prevent chipping of the nail lacquer from the nails. In some individuals using these products, the nails became yellowed and thickened with subungual "splinter hemorrhages" and a mild tender paronychial inflammation. In patients so reacting patch tests applied to the skin with the product were positive. After cessation of the use of the product the nails required approximately four months for regrowth and return to normal. The noxious ingredient causing this reaction may be a small percentage of free phenol. The Toilet Goods Association has recommended to its members that these products be withdrawn from sale, pending further research.



A Wartime Consultation

CHARLES W. McGAVRAN, M. D.

IT was January 22, 1918, and the thermometer stood at zero. I was summoned to Frazeysburg, Ohio (the wettest spot on earth in the summer, and the coldest in America in the winter). My train was one hour and thirty minutes late in reaching "The Burg," and my last chance of getting a train home that night had disappeared when number three came along, stopped and started while I was far away.

My consultation was over. I was hungry—had only had one meal thus far that day and that was corn fritters at eleven, a combined breakfast and luncheon. Yes, I was hungry—it was now eight o'clock in the evening. My good friend, Dr. Burnside, took me to a restaurant. It was a meatless day so I ordered two eggs, bread and coffee. The doctor said he would send me over the hills to Nashport (my, how I remember that name), a town four miles away where I could catch (catch is right) an electric which would take me home. I ate hurriedly, each egg chasing the other down in tandem fashion—one, at least, reaching my stomach. The bread was then swallowed with a large cup of coffee, in hopes that it would act as a chest warmer, for I knew the distance to my stomach was very great. Just as I gulped the last of my coffee, Joe Blaizer came in. Joe was a tall, lean, lank individual—reminded me somewhat of a lone corn stalk that had been missed by the cutters. He was warmly clad—large high boots with felt gaiters, two overcoats, fur cap with visor pulled down over his eyes, a large black muffler around his neck, head and face through which only the beak of a rather prominent nose could be seen. I am sorry that I did not get to see more of Joe, for from his subsequent behavior I would expect him to have a kind face—not pretty—not particularly strong, just kind. I was informed that we were to go in a sleigh and that the team was now hitched.

You can imagine how a fellow kept in the city all winter in a closed car would feel in anticipation of one of those good old-fashioned, cross country sleigh rides on a bright winter night. A feeling somewhat like the one I had the night before I put on my first long pants—Oh, how grand it would be.

Joe asked me to walk with him around to the barn where the sleigh was ready. The horses, a fine pair of mares, were just a trifle on the lean order. It was not necessary to ask if they had been Hooverizing. Joe lead them out and then turned to close the barn door. We heard a rustle, looked up, and Joe with eyes as large as the opening in a 42 cm. howitzer, exclaimed: "By Blankety, if them blankety blank mares hain't run away!" And sure enough, about a block away we could see them starting for their country home four miles away. I started after them, the snow was only 18 inches deep, but I was thinking of Nashport and getting back home. Finally Joe overtook me and called: "Come back, you fool, you never can catch a team by running after them!" So I returned to the restaurant, steaming in perspiration and a little hot under the collar. It was not necessary to ask for anything more to eat, for my run in the snow had only released the second egg from it's bearing in the esophagus. The bread and coffee were still there, however, in the form of a huge lump in my throat. While passing the time I phoned home to my wife and told her how very comfortable I was, adding that I expected to be home about midnight.

Finally someone sounded an alarm. Joe was at the door in the sleigh. The mares were steaming. Joe had telephoned ahead, about a mile and a half out, and they had caught the team. Poor Joe had walked out and brought them back. He was steaming too. I looked at the sleigh and it took me back twenty years when we used to have sleighs over at Cadiz,

Ohio. Why, there was no windshield, no pneumatic tires, just a sleigh! Joe said, "Better git in." I was leaving the time all to Joe, for he said he would take me to Nashport in time for the train so I asked no questions.

I did as I was commanded and got in. Joe said, "It's mighty cold tonight, guess we'll turn this lantern pretty high and put 'er between our feet. Sometimes it's easier to keep from getting frozen than to thaw out after yer frozen." Of course, that sounded good to me. I was still enthuisastic over the prospect of a good 'old-fashioned' sleigh ride. We wrapped ourselves in blankets, one of which was all covered with snow and ice, but that did not matter for on this trip it would not have a chance to thaw, no, I'm sure that it did not!

Now we were off. Oh! that delightful sensation, a sleigh ride, just think of it! The night was fine, the sky was clear, not a cloud to be seen, and save for the rumble of an occasional freight in the distance, all was quiet. Oh, yes, there was that delightful jingle of the sleigh bells, which had been loosely strapped around the girth of each of the mares. Soon I noticed that the upholstering on the sleigh was not so deep nor so soft as that of my coupe, and then to my surprise I began to get cold—yes, the thermometer was below zero.

For the first mile the road was clear, then we struck the drifts. We were first on this side of the road and then on that, then on top of a drift looking down on top of the fence. We were getting cold. I say we, for old Joe had reached under the blankets and was warming his hands on the lantern. We were now reaching the ridge. The mares were going slowly and cautiously. Joe talked incessantly—I was glad he did for it helped to keep my mind off the cold. He told me all about his experience in North Dakota in the winter of 1888—of the terrible blizzard of January of that year when with the cold wind sweeping down from the north the temperature dropped from 70 degrees above zero to 40 degrees below zero in twenty-four hours. He told, with intense feeling, of the great suffering caused by the bitter cold and the strong wind, and stated that the snow drifts were very deep, in places from 2 to 30 feet.

Suddenly he turned and said, "Do you see that stretch of road ahead, just beyond the edge of the woods with the opening between the hills? Well, that's one of the coldest spots in all America." I said, no room for argument, "I concede." And then he had the audacity to say, "But it'll not be so cold on me coming home for the wind will be on my back." I said that that would be fine.

Cold! I should say it was! My head and ears were well covered and I had on my fur coat, but my face—it just gradually froze stiff. My breath formed icicles on my glasses, which upon coming in contact with my cheeks, froze solid. Yes, I was cold. We came to a place where the road was no longer passable. We drove through woods, through orchards and through fields, and finally after an hour, which seemed hours to me, Joe pulled up with a sudden, "Whoa—well, we're here."

"What?," I said, "I thought you were taking me to Nashport."

"Well, this is Nashport. That is, this is the Nashport Station. Nashport is about three-fourths of a mile over the hill."

"Well, let's go into the station and warm up."

"No," said Joe, "the station closes at seven o'clock. You will have to wait on the platform till the car comes. Let's see, it's now five, six, just seven minutes after nine and your car is due at 10:28. Your car comes from Zanesville, which is down that way," pointing (I suppose to the east), "and goes that way," pointing (I suppose to the west). "Now here is the way to signal the car—you see this string?—when you pull it down it shows the light and signals the car, so when you see the car coming, just pull the string."

Here I was at Nashport Station, hands cold, feet cold and face frozen, three-fourths of a mile away from Nashport (I wonder what kind of a Port it is?), and over one half a mile from the nearest farmhouse. The thermometer was below zero and there was eighteen inches of snow on the ground with a howling wind filling up every track in the already drifted road.

Oh, the loneliness, that homesick feeling that comes over a fellow when he thinks of being left alone, alone at a road crossing, with one hour and twenty-one minutes to wait on his last and only chance to reach home that night. It's wonderful what visions a fellow may have in a fraction of a minute. Why, I saw my car ditched and the track blocked. I heard a message go over the wire from the fuel dictator, no more cars can run tonight. I even saw Garfield, himself, standing on the tracks at Zanesville with arms outstretched, saying 'no more cars tonight.' Then, keenly feeling the cold, for my hands and face were beginning to ache, I saw myself standing alone by the side of a track in a strange country with no one to whom to appeal in the event of an emergency, and no place to go in the event my car failed to come. All this went through my head like a flash!

I said, "Joe, how much do I owe you?"

Joe rubbed the end of his nose—that's all of his face that was showing, pulled down his muffler so he could take a chew of tobacco, and said, "Well, I don't want to be hard on ye, but this here's been a hard trip, hain't it? Do ye reckon that three dollars would be too

steep?" My heart turned over—I was afraid he would say ten!

"No, Joe, that is not too much, but, Joe, I will not give you three dolars. I'm giving you four, but say, Joe, the condition is you are to stay with me and see me on my car."

Joe said he would and thereupon I counted out four dollars as rapidly as my stiff fingers would permit. Just then I felt a splash, a sort of jar, and I realized that my esophagus, which had been under such tension all of this time, had relaxed, permitting the remainder of my supper to drop into my stomach!

They say that one should never gloat over another's misfortune or sufferings, but the fact is, Joe, too, was cold. I wondered how cold he really was, but that does not matter, he was cold enough. He drove the mares into a stall. The stall reminded me of one of those private stalls they used to have around a country church before the farmers began to drive flivvers. He properly blanketed the mares, and then, to my surprise and delight, began to tear posters from the side of the shed:—Barnum & Bailey, Ringling Brothers and others had been very generous with those bills and there must have been twenty years' thickness sticking on the walls. He soon had a great arm full. He then began kicking down a partition between the stalls. This was promptly accomplished, and I could see from the way he was working that he really was cold. Over by the side of the road, close to the track, was a huge pile of ties. It would make a good wind break, and he decided to build a fire there.

It took him but a moment to tramp a place in the 18 inches of snow, about one yard in diameter, and here we built the fire. I found some crates, half covered with snow—they looked like chicken crates, but that did not matter—too cold to ship chickens now—and anyhow, Garfield had said nothing about the use of crates in his statement on the conservation of fuel. Oh! That fire! I have never appreciated a fire so much in my life. Soon we had the flame, the crackling of the pine boards, the sizzling of the snow on the crates, all of which made a combination which sent a thrill of joy to my very bones, and with it came a sense of warmth.

Suddenly the wind shifted, blowing the hot smoke right into our faces, causing us to sneeze, and our eyes to water. Just then I felt my glasses break loose from my face. I was actually beginning to thaw!

Joe, as I said, talked incessantly and really had a sense of humor. When the fire became hot, Joe suddenly turned and said, "Well, boys, the water's hot, kill the hog." Strange as it may seem, the same thought had at that moment occurred to me. I tell you the boy who has never gotten up before daylight, tramped through the snow, built a fire, filled the kettle and scalded a hog, has missed an experience which every boy ought to have.

Of course, my main object was to get home. I could not keep my mind off the car. Finally, I said, "Joe, why not tie that rope down so the signal will constantly show 'stop'"?

"Good idea," said Joe.

Accordingly he dived into his tool box. I don't know which pocket it was, but every handy man in a country village always has one particular pocket which he uses as a carry-all. He brought out a spike and a pair of tweezers, and went up and nailed the rope down. The car, if she came, would stop, anyway. Joe would see me on my car.

So we stood around the fire, just Joe and I. Joe was talking, chewing and spitting. I was listening, thinking and smoking. We would hold one foot over the blaze, then the other, the warm foot coming back in contact with the snow, melting it, causing a layer of ice all around the fire. Now we would bend down close over the fire, warming one hand, then the other, breathing in that blessed heat. It's remarkable how a very cold person can actually put his hands and feet in the very blaze without getting burned. That is exactly what we did. But now we were warm, that is, that portion of us turned toward the fire was comfortable, so we would stand facing the fire, then turning our backs to it—always keeping our hands to our backs when our back was turned towards the fire. Joe was still talking. He told of selling 11 Fords in one afternoon, of drilling oil wells, of raising 200 bushels of wheat on one acre of ground, of selling wool at 7½ cents a pound. He told about driving 20 miles in North Dakota to see a doctor who cured him of consumption for $1.50. Yes, Joe was surely one good entertainer.

Finally, after what seemed hours of waiting, tramping, turning and stooping in our efforts to keep warm, the blaze was dying down—only the red hot embers remaining, I heard a toot-toot and looking down the road I saw a car approaching. It was not necessary to pull the signal, Joe had already attended to that with the spike. The car was there. I asked the conductor if the car would take me to Columbus, and after he said it would, I grasped as much of Joe's big hand as I could hold, and gripping it tightly, I said, "Goodnight, Joe, I thank you for your kindness, and hope you get back safe and sound," then, as I stepped up on the platform, "Am mighty glad that that wind will be to your back on your homeward trip—goodnight."

Then I was off—really getting away from Nashport Station. My supper began to digest. I seemed to be alive once more. At one o'clock in the morning I was home and soon in bed. The trip to Frazeysburg was past history, BUT NEVER TO BE FORGOTTEN!!!



ANNOUNCING

Official Program

for the

1949 ANNUAL MEETING

OHIO STATE MEDICAL ASSOCIATION

April 19, 20, 21, 22, 1949

ON this and the following pages will be found detailed information on the program and schedule of events for the 1949 Annual Meeting of the Ohio State Medical Association.

TIME AND PLACE: Tuesday, Wednesday, Thursday and Friday, April 19, 20, 21 and 22; the Neil House and the Deshler-Wallick Hotel, Columbus, Ohio. These two downtown hotels face the State House square and are only a half square apart.

REGISTRATION: The Registration Headquarters and General Information Booth will be on the Mezzanine Floor of the Neil House, opening daily at 8 a. m. and closing at 6 p. m., except Friday, April 22, when closing hour will be 12 o'clock noon. There will be no registration charge. Admission to all sessions will be by badge secured at Registration Headquarters. Those eligible to register are: Members of the Ohio State Medical Association (who should have 1949 membership cards for presentation at time of registration); physicians from other states who are members of their state medical society; residents, interns, medical students, nurses, health workers, and others who are presented at Registration Headquarters by members.



SCIENTIFIC SESSIONS: Scientific and clinical sessions will be divided between the Neil House and the Deshler-Wallick Hotel. Section meetings will be from

9 a. m. to 12 noon on three successive days. See detailed program on following pages for exact place and day scheduled.

MEDICAL TOPICS OF THE DAY: This series is a new feature and is being introduced at this year's Annual Meeting. On Wednesday afternoon from 3:35 to 5:15 p. m., five discussion groups will be held, during which some of the most recent developments in medicine and surgery will be discussed.

ROUND-TABLE DISCUSSIONS: This year for the first time the Annual Meeting is being extended to include part of a fourth day. On Friday morning, six round-table discussions are scheduled. These discussions will include some of the medical problems most frequently encountered by physicians. See Friday's program for subjects.

INSTRUCTIONAL COURSES: These courses conducted during the last two annual meetings created a great deal of interest and favorable comment. Instructional Courses will follow the line of panel discussions, with a moderator and discussants, on some of the current medical and surgical problems. Courses are especially designed to provide members with practical instruction on the handling of clinical problems arising in everyday practice—especially in the general practice of medicine.

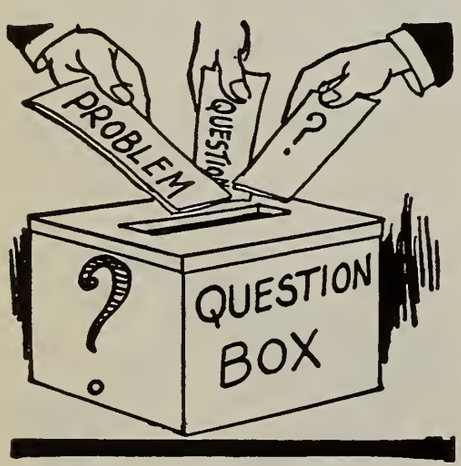


Specially selected clinicians will serve as moderators and as participants in the informal discussions. Time will be allowed for questions and answers.

Eighteen courses will be presented—six different courses on each of three successive days. See programs under Tuesday, Wednesday and Thursday for details.

Attendance at the Instructional Courses will be limited. Admission will be by ticket only. Therefore, those planning to attend the Instructional Courses should apply for tickets in advance of the meeting.

A special folder on the Instructional Courses and other Annual Meeting events will be mailed to each member in the near future. This folder should be read carefully since it will give information on how to secure Instructional Course tickets.



An application envelope for ordering Instructional Course tickets will accompany the folder. This envelope should be filled out, per instructions, and mailed to the Columbus Headquarters Office where applications will be filled. Because of limited facilities, applications will be filled on a first-come, first-served basis. It will be advisable to secure Instructional Course tickets by mail to insure admission to the courses desired. Tickets will be mailed well in advance of the meeting to those who apply. There will be no registration fee for the courses, nor will there be a registration fee for any of the scientific sessions.

Tickets for the Annual Banquet may be ordered by mail also. Members may order tickets for the Banquet at the same time that they order tickets for the Instructional Courses. The Banquet is essentially a social function. Tickets will cost $5.50 each.

SPECIALTY SOCIETIES: Several specialty societies have announced special meetings during the Association's Annual Meeting. The Annual Meeting of the Ohio

State Radiological Society will meet in Private Dining Room No. 4, Neil House, at 9 a. m., Wednesday. The Obstetrical and Gynecological Societies of Cincinnati, Cleveland and Columbus will have a cocktail hour at 5:30 p. m., Tuesday, at the Athletic Club of Columbus, followed by dinner at 7 p. m. The Ohio Chapter of the American College of Chest Physicians will meet in Private Dining Room No. 5, Neil House, Wednesday, April 20, at noon for a luncheon session. The Annual Meeting of the Ohio Academy of General Practice will be held at 8 p. m., Tuesday, April 19, in the Main Ballroom of the Neil House.

PANELS ON MEDICAL ECONOMICS: In addition to keeping up with the many new scientific developments, physicians yearly are finding themselves faced with more so-called economic questions. Therefore, Thursday evening will be devoted to a question-and-answer session on the procedures and operations of the Ohio Industrial Commission, the Ohio Department of Public Welfare, and the Ohio Department of Health, agencies with which the average physician deals almost daily. Efforts will be made at this "Information Please" program to provide the audience with answers to some of the important questions physicians may have as a result of their dealings with these three departments.



SCIENTIFIC EXHIBIT: A fine display of Scientific Exhibits will be housed in the Main Ballroom, Mezzanine Floor, Deshler-Wallick Hotel. Physicians will find many interesting and educational displays in this exhibit. The Exhibit will be open daily from 9 a. m. to 6 p. m., except Friday when closing time will be 12 noon.

TECHNICAL EXHIBIT: This exhibit will consist of 61 displays of pharmaceuticals, equipment, books, etc., and will be housed in the Mezzanine Lounge and Junior Ballroom, Neil House. The Exhibit will be open daily from 9 a. m. to 6 p. m., except Friday when closing time will be 12 noon.

HOUSE OF DELEGATES: First session of the House of Delegates will be a dinner meeting at 6 p. m., Tuesday, April 19, in the Hall of Mirrors, Deshler-Wallick Hotel. Second session will be a luncheon and afternoon meeting, beginning at 12 noon, Thursday, April 21, in the same hall.

ANNUAL BANQUET: This social event will be held in the Main Ballroom, Mezzanine Floor, Neil House, on Wednesday, April 20, beginning at 7:30 p. m. Formal dress will be optional. There will be no speeches—members will have this opportunity to relax from the educational program. A program of entertainment will be followed by an evening of dancing. Tickets at $5.50 each will be available in advance of the meeting on application, accompanied by check, to the Columbus Headquarters Office. During the meeting tickets will be available to the limit of available facilities. There will be a limit on the number of tickets sold because of limited facilities.



WOMAN'S AUXILIARY: The Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held at the Seneca Hotel, Columbus, April 19, 20 and 21. See program in this issue.

TUESDAY, APRIL 19

TIME	SECTION ON SURGERY Main Ballroom, Mezzanine Floor Neil House *(See following pages for details)*	SECTION ON ANESTHESIOLOGY Parlors A, B, C, Mezzanine Floor Deshler-Wallick Hotel *(See following pages for details)*
9:00 A.M. to 12:00 Noon		
12:00 Noon to 1:30 P.M.	RECESS FOR LUNCHEO	
1:30 P.M. to 3:00 P.M.	**Instructional Course 1** Private Dining Room No. 2, Mezzanine Floor Neil House **PRESENT-DAY MANAGEMENT OF COMPOUND FRACTURES** MAXWELL HARBIN, M.D. Cleveland, Moderator *(See following pages for details)*	**Instructional Course 2** Main Ballroom Mezzanine Floor Neil House **SUPPURATIVE DISEASES OF THE CHEST** EDWARD J. McGRATH, M.D. Cincinnati, Moderator *(See following pages for details)*
	Instructional Course 3 Hall of Mirrors Wallick Addition Deshler-Wallick Hotel **SPINAL ANESTHESIA** ROLLAND J. WHITACRE, M.D Cleveland, Moderator *(See following pages for details)*	
3:00 P.M. to 3:30 P.M.	RECESS FOR VISITING	
3:35 P.M. to 4:05 P.M.	CANCER CONTROL Charles S. Cameron, M.D. New York, N.Y.	
4:10 P.M. to 4:40 P.M.	THE CRIPPLED LUNG Joseph W. Gale, M.D. Madison, Wis.	
4:45 P.M. to 5:15 P.M.	ANESTHESIOLOGY AS AN AID TO DIAGNOSIS AND TREATMENT Henry S. Ruth, M. D. Philadelphia, Pa.	
6:00 P.M.	DINNER FOR MEMBERS OF THE HOUSE OF DELEGATES AND THE FIRST	
7:00 P.M.	DINNER MEETING OF THE OBSTETRICAL AND GYNECOLOGICAL	
8:00 P.M.	ANNUAL MEETING OF THE OHIO ACADEMY OF GENERAL PRACTICE,	

MEETING—1949

NEIL HOUSE AND DESHLER-WALLICK HOTEL, COLUMBUS

TUESDAY, APRIL 19

SECTION ON EYE, EAR, NOSE AND THROAT

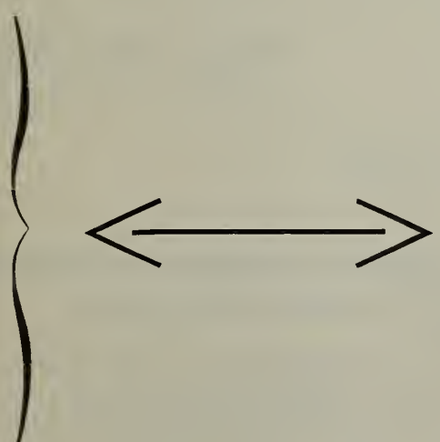
Hall of Mirrors, Wallick Addition
Deshler-Wallick Hotel

(See following pages for details)

AND VISITING THE EXHIBITS

Instructional Course 4	Instructional Course 5	Instructional Course 6
Private Dining Room No. 4 Mezzanine Floor Neil House	Parlors H, I, J Wallick Addition Deshler-Wallick Hotel	Parlors A, B, C Mezzanine Floor Deshler-Wallick Hotel
MANAGEMENT OF THERMAL BURNS	**COMMON DISORDERS OF THE ANUS, RECTUM AND COLON**	**MANAGEMENT OF PATIENTS WITH INOPERABLE NEOPLASMS**
CARL A. HAMANN, M.D. **Cleveland, Moderator**	**HENRY A. CRAWFORD, M.D.** **Cleveland, Moderator**	**CHARLES M. BARRETT, M.D.** **Cincinnati, Moderator**
(See following pages for details)	*(See following pages for details)*	*(See following pages for details)*

THE EXHIBITS



GENERAL SESSION

MAIN BALLROOM, MEZZANINE FLOOR
NEIL HOUSE

Louis G. Herrmann, M.D., Chairman,
Committee on Scientific Work, Presiding

BUSINESS SESSION, HALL OF MIRRORS, WALLICK ADDITION, DESHLER-WALLICK HOTEL

SOCIETIES OF CINCINNATI, CLEVELAND, AND COLUMBUS, ATHLETIC CLUB

MAIN BALLROOM, MEZZANINE FLOOR, NEIL HOUSE

WEDNESDAY, APRIL 20

TIME	SECTION ON GENERAL PRACTICE	SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE
9:00 A.M. to 12:00 Noon	Main Ballroom, Mezzanine Floor Neil House *(See following pages for details)*	Parlors A, B, C, Mezzanine Floor Deshler-Wallick Hotel *(See following pages for details)*
12:00 Noon	LUNCHEON MEETING OF OHIO CHAPTER OF THE AMERICAN COLLEGE O	
12:00 Noon to 1:30 P.M.	RECESS FOR LUNCHEO	

TIME	Instructional Course 7	Instructional Course 8	Instructional Course 9
1:30 P.M. to 3:00 P.M.	Main Ballroom Mezzanine Floor Neil House **MODERN METHODS OF THERAPY FOR EARLY SYPHILIS** JOHN D. PORTERFIELD, M.D. Columbus, Moderator *(See following pages for details)*	Private Dining Room No. 3 Mezzanine Floor Neil House **ACCIDENTS OF LABOR** PHILLIPS K. CHAMPION, M.D. Dayton, Moderator *(See following pages for details)*	Private Dining Room No Mezzanine Floor Neil House **DISEASES OF THE GALLBLADDER** ROBERT T. ALLISON, Jr., M.D. Akron, Moderator *(See following pages for details)*
3:00 P.M. to 3:30 P.M.	RECESS FOR VISITIN		

TIME	MEDICAL TOPICS OF THE DAY		
	NEW ADVANCES IN HEMATOLOGIC THERAPY	**SURGERY OF THE GASTRO-INTESTINAL TRACT**	**ACUTE ARTHRITIS: DIAGNOS AND TREATMENT**
3:35 P.M. to 5:15 P.M.	Main Ballroom Mezzanine Floor Neil House CHARLES A. DOAN, M.D. Columbus, Moderator *(See following pages for details)*	Hall of Mirrors Wallick Addition Deshler-Wallick Hotel THOMAS E. JONES, M.D. Cleveland, Moderator *(See following pages for details)*	Parlors A, B, C Mezzanine Floor Deshler-Wallick Hotel MARION A. BLANKENHORN, M.D. Cincinnati, Moderator *(See following pages for details)*
7:30 P.M.	ANNUAL BANQUET, MAIN BALLROO		

MEETING—1949

NEIL HOUSE AND DESHLER-WALLICK HOTEL, COLUMBUS

WEDNESDAY, APRIL 20

SECTION ON OBSTETRICS AND GYNECOLOGY
Hall of Mirrors, Wallick Addition
Deshler-Wallick Hotel
(See following pages for details)

OHIO STATE RADIOLOGICAL SOCIETY
Private Dining Room No. 4
Mezzanine Floor, Neil House
(See following pages for details)

IEST PHYSICIANS, PRIVATE DINING ROOM NO. 5, MEZZANINE FLOOR, NEIL HOUSE

ND VISITING THE EXHIBITS

Instructional Course 10
Parlors A, B, C
Mezzanine Floor
Deshler-Wallick Hotel

ABDOMINAL EMERGENCIES OF THE NEWBORN
DONALD M. GLOVER, M.D.
Cleveland, Moderator
(See following pages for details)

Instructional Course 11
Parlors H, I, J
Wallick Addition
Deshler-Wallick Hotel

RHEUMATOID ARTHRITIS
ROBERT M. STECHER, M.D.
Cleveland, Moderator
(See following pages for details)

Instructional Course 12
Hall of Mirrors
Wallick Addition
Deshler-Wallick Hotel

THE USE OF ANTIBIOTICS IN THE FIELD OF PEDIATRICS
CHARLES F. McKHANN, M.D.
Cleveland, Moderator
(See following pages for details)

HE EXHIBITS

MEDICAL TOPICS OF THE DAY

HE RECOGNITION AND MANAGEMENT OF THYROID DISEASE
Parlors H, I, J, Wallick Addition
Deshler-Wallick Hotel
GEORGE M. CURTIS, M.D.
Columbus, Moderator
(See following pages for details)

ACUTE CARDIORESPIRATORY FAILURE: REQUIREMENTS FOR SUCCESSFUL RESUSCITATION
Private Dining Room No. 4
Mezzanine Floor, Neil House
CLAUDE S. BECK, M.D.
Cleveland, Moderator
(See following pages for details)

MEZZANINE FLOOR, NEIL HOUSE

THURSDAY, APRIL 21

TIME	SECTION ON MEDICINE	SECTION ON NERVOUS AND MENTAL DISEASE
9:00 A.M. to 12:00 Noon	Main Ballroom Mezzanine Floor Neil House *(See following pages for details)*	Parlors H, I, J, Wallick Addition Deshler-Wallick Hotel *(See following pages for details)*
12:00 Noon	LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES AND FINA	
12:00 Noon to 1:30 P.M.	RECESS FOR LUNCHEON	
1:30 P.M. to 3:00 P.M.	**Instructional Course 13** Room 1337 Deshler-Wallick Hotel **PROBLEMS OF PREMATURITY** J. VICTOR GREENEBAUM, M.D. Cincinnati, Moderator *(See following pages for details)*	**Instructional Course 14** Private Dining Room No. 4 Mezzanine Floor Neil House **EVALUATION AND MANAGEMENT OF HYPERTENSION** EUGENE B. FERRIS, M.D. Cincinnati, Moderator *(See following pages for details)*
	Instructional Course 15 Main Ballroom Mezzanine Floor Neil House **CIRRHOSIS OF THE LIVER** A. J. BEAMS, M.D. Cleveland, Moderator *(See following pages for details)*	
3:00 P.M. to 3:30 P.M.	RECESS FOR VISITING	
3:35 P.M. to 4:05 P.M.	PSYCHIATRIC ASPECTS OF MEDICINE Kenneth E. Appel, M.D. Philadelphia, Pa.	
4:10 P.M. to 4:40 P.M.	DIAGNOSIS AND TREATMENT OF EARLY POLIOMYELITIS Philip M. Stimson, M.D. New York, N.Y.	
4:45 P.M. to 5:15 P.M.	RECENT DEVELOPMENTS IN VIRAL HEPATITIS AND OTHER LIVER DISEASE John R. Neefe, M.D. Philadelphia, Pa.	
8:00 P.M.	**"INFORMATION, PLEASE"** Informal question-and-answer session and discussions by three panels on the activities and operations of the Ohio Industrial Commission, Ohio Department of Public Welfare, and Ohio Department of Health, as they relate to the day-by-day practice of the physician. . . . See following pages for details and names of participants.	

MEETING—1949

NEIL HOUSE AND DESHLER-WALLICK HOTEL, COLUMBUS

THURSDAY, APRIL 21

SECTION ON PEDIATRICS

Parlors A, B, C, Mezzanine Floor
Deshler-Wallick Hotel

(See following pages for details)

USINESS SESSION, HALL OF MIRRORS, WALLICK ADDITION, DESHLER-WALLICK HOTEL

AND VISITING THE EXHIBITS

Instructional Course 16

Parlors H, I, J
Wallick Addition
Deshler-Wallick Hotel

DERMATOSES OF INTEREST TO THE GENERAL PRACTITIONER

HAROLD N. COLE, M.D.
Cleveland, Moderator

(See following pages for details)

Instructional Course 17

Private Dining Room No. 2
Mezzanine Floor
Neil House

MANAGEMENT OF THE UNCONSCIOUS PATIENT

MAX T. SCHNITKER, M.D.
Toledo, Moderator

(See following pages for details)

Instructional Course 18

Parlors A, B, C
Mezzanine Floor
Deshler-Wallick Hotel

INFANT FEEDING

A. A. WEECH, M.D.
Cincinnati, Moderator

(See following pages for details)

THE EXHIBITS

GENERAL SESSION

MAIN BALLROOM, MEZZANINE FLOOR
NEIL HOUSE

Charles A. Doan, M.D., Member
Committee on Scientific Work, Presiding

GENERAL SESSION

MAIN BALLROOM, MEZZANINE FLOOR
NEIL HOUSE

FRIDAY, APRIL 22

TIME	ROUND-TABLE DISCUSSIONS		
	INDUSTRIAL TOXICOLOGY	**PRE-ECLAMPSIA AND ECLAMPSIA**	**ALLERGY FOR THE GENERAL PRACTITIONER**
9:00 A.M. to 12:00 Noon	Parlors H, I, J Wallick Addition Deshler-Wallick Hotel	Private Dining Room No. 4 Mezzanine Floor Neil House	Main Ballroom Mezzanine Floor Neil House
	ROBERT A. KEHOE, M.D. Cincinnati, Moderator	ALLAN C. BARNES, M.D. Columbus, Moderator	JONATHAN FORMAN, M.D. Columbus, Moderator
	(See following pages for details)	*(See following pages for details)*	*(See following pages for details)*

SCIENTIFIC EXHIBIT, MAIN BALLROOM

MEZZANINE FLOOR

DESHLER-WALLICK HOTEL

REGISTRATION HEADQUARTERS . . . GENERA

MEETING—1949

NEIL HOUSE AND DESHLER-WALLICK HOTEL, COLUMBUS

FRIDAY, APRIL 22

ROUND-TABLE DISCUSSIONS

CURRENT TRENDS IN TREATMENT OF DIABETES MELLITUS

Parlors A, B, C
Mezzanine Floor
Deshler-Wallick Hotel

GEORGE M. GUEST, M.D.
Cincinnati, Moderator

(See following pages for details)

CARDIOVASCULAR RENAL DISEASE: NEWER DEVELOPMENTS IN DIAGNOSIS AND TREATMENT

Hall of Mirrors
Wallick Addition
Deshler-Wallick Hotel

ROY W. SCOTT, M.D.
Cleveland, Moderator

(See following pages for details)

THE JAUNDICED PATIENT

Private Dining Room No. 2
Mezzanine Floor
Neil House

FRANK M. BARRY, M.D.
Cleveland, Moderator

(See following pages for details)

TECHNICAL EXHIBIT, MEZZANINE LOUNGE AND JUNIOR BALLROOM NEIL HOUSE

INFORMATION . . . MEZZANINE FLOOR, NEIL HOUSE

TUESDAY, APRIL 19

9:00 A. M.

SECTION ON SURGERY

Main Ballroom, Mezzanine Floor
Neil House

PROGRAM COMMITTEE

Robert M. Zollinger, M. D., Columbus, Section Chairman
John W. Holloway, M. D., Cleveland, Section Secretary
Vinton E. Siler, M. D., Cincinnati
Max T. Schnitker, M. D., Toledo
Frederick T. Merchant, M. D., Marion

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:30

TREATMENT OF POST-PHLEBITIC ULCER OF THE LEG BY A PHLEBECTOMY AND SYMPATHECTOMY

Richard Hotz, M. D., Toledo.

9:30 to 9:45

PRESENT CONCEPTS IN THE DIAGNOSIS AND TREATMENT OF ACUTE PANCREATITIS

Vinton E. Siler, M. D., and John Wulsin, M. D., Cincinnati.

9:45 to 10:00

MANAGEMENT OF MASSIVE UPPER GASTRO-INTESTINAL HEMORRHAGE

Stanley O. Hoerr, M. D., Columbus.

10:00 to 10:15

THE MANAGEMENT OF APPENDICEAL ABSCESSES

William P. Montanus, M. D., Springfield.

10:15 to 10:30

THE ETIOLOGY AND RATIONALE OF TREATMENT OF COMMON DUCT PATHOLOGY

H. Vern Sharp, M. D, Akron.

10:30 to 11:15

CURRENT TRENDS IN THE TREATMENT OF HERNIA

Frank Glenn, M. D., New York, N. Y.

11:15 to 11:30

EARLY MANAGEMENT OF INJURIES OF THE FACE AND JAWS

Bruce Martin, M. D., Columbus.

11:30 to 12:00

PANEL DISCUSSION ON SUBJECTS PRESENTED DURING THE MORNING

Moderator: Stanley O. Hoerr, M. D., Columbus.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

TUESDAY, APRIL 19

9:00 A. M.

SECTION ON ANESTHESIOLOGY

Parlors A, B, C, Mezzanine Floor
Deshler-Wallick Hotel

PROGRAM COMMITTEE

Carl R. Damron, M. D., Mansfield, Section Chairman
George F. Collins, M. D., Columbus, Section Secretary
A. L. Schwartz, M. D., Cincinnati
Paul L. Yordy, M. D., Dayton
K. C. McCarthy, M. D., Toledo

9:00 to 10:15

PANEL DISCUSSION—REGIONAL ANESTHESIA

Moderator: F. W. Clement, M. D., Toledo.

1. Brachial Block—Robert D. Myers, M. D., Columbus.
2. Intercostal Block—J. J. Jacoby, M. D., Columbus.
3. Caudal Block—Leslie A. Patten, M. D., Columbus.
4. Stellate Block—F. A. Oldenberg, M. D., Akron.
5. Digital Wrist and Ankle Blocks—Paul L. Yordy, M. D., Dayton.

10:15 to 11:00

ANESTHESIA IN THORACIC SURGERY

Henry S. Ruth, M. D., Philadelphia, Pa.

11:00 to 11:15

RECESS

11:15 to 11:30

ANESTHESIA FOR THE CARDIAC PATIENT

B. B. Sankey, M. D., Cleveland.

11:30 to 11:45

REPLACEMENT FLUID THERAPY DURING ANESTHESIA

Donald E. Hale, M. D., Cleveland.

11:45 to 12:00

BUSINESS MEETING

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

TUESDAY, APRIL 19

9:00 A. M.

SECTION ON EYE, EAR, NOSE AND THROAT

Hall of Mirrors, Wallick Addition
Deshler-Wallick Hotel

PROGRAM COMMITTEE

Horace W. Reid, M. D., Cincinnati, Section Chairman
Norvil A. Martin, M. D., Gallipolis, Section Secretary
Ralph H. Miller, M. D., Cincinnati
S. C. Yinger, M. D., Springfield
Arthur M. Culler, M. D., Columbus

9:00 to 9:25

TRANSPLANTATION OF THE CORNEA

(Sight Restoration Work at the Cleveland Society for the Blind)

William Evans Bruner, M. D., and C. I. Thomas, M. D., Cleveland.

9:25 to 9:30

GENERAL DISCUSSION

9:30 to 9:55

CYCLODIALYSIS: ITS INDICATIONS AND TECHNIQUE

K. W. Ascher, M. D., Cincinnati.

9:55 to 10:00

GENERAL DISCUSSION

10:00 to 10:25

OZENA: RECENT THERAPEUTIC TRENDS

William Thornell, M. D., Cincinnati.

10:25 to 10:30

GENERAL DISCUSSION

10:30 to 10:45

BUSINESS MEETING

10:45 to 10:55

AN INFORMATIVE REPORT ON THE WELFARE OF THE BLIND AND THE BLIND SCHOOL

Claude S. Perry, M. D., Columbus, Consultant to the Ohio Commission for the Blind.

10:55 to 11:10

REPORT ON THE RESULTS OF THE FIRST YEAR'S OPERATION OF THE HEARING CONSERVATION PROGRAM

John D. Porterfield, M. D., Columbus, Director, Ohio Department of Health.

11:10 to 11:15

QUESTION-AND-ANSWER PERIOD

11:15 to 11:45

DISEASES OF THE SALIVARY GLANDS

A. C. Furstenberg, M. D., Ann Arbor, Mich.

11:45 to 12:00

GENERAL DISCUSSION

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

TUESDAY, APRIL 19

1:30 to 3:00 P. M.

INSTRUCTIONAL COURSES

(Admission by Ticket Only)

1. **PRESENT-DAY MANAGEMENT OF COMPOUND FRACTURES**

Private Dining Room No. 2, Mezzanine Floor, Neil House

Moderator: Maxwell Harbin, M. D., Cleveland.

Panel Discussants: Harlan Wilson, M. D., Columbus; Theodore H. Vinke, M. D., Cincinnati; W. H. McGaw, M. D., Cleveland.

2. **SUPPURATIVE DISEASES OF THE CHEST**

Main Ballroom, Mezzanine Floor, Neil House

Moderator: Edward J. McGrath, M. D., Cincinnati.

Panel Discussants: (To be selected)

3. **SPINAL ANESTHESIA**

Hall of Mirrors, Wallick Addition, Deshler-Wallick Hotel

Moderator: Rolland J. Whitacre, M. D., Cleveland.

Panel Discussants: Henry S. Ruth, M. D., Philadelphia, Pa.; A. J. Fisher, M. D., Youngstown; Max Krakauer, M. D., Cincinnati; Earl Knisely, M. D., Columbus; William A. Friend, M. D., Akron; Lloyd Larrick, M. D., Cincinnati.

4. **MANAGEMENT OF THERMAL BURNS**

Private Dining Room No. 4, Mezzanine Floor, Neil House

Moderator: Carl A. Hamann, M. D., Cleveland.

Panel Discussants: Harold J. Bowman, M. D., Canton; Byron E. Boyer, M. D., Cincinnati; Clifford L. Kiehn, M. D., Cleveland.

5. **COMMON DISORDERS OF THE ANUS, RECTUM AND COLON**

Parlors H, I, J, Wallick Addition, Deshler-Wallick Hotel

Moderator: Henry A. Crawford, M. D., Cleveland.

Panel Discussants: Clayton C. Perry, M. D., Cleveland; Wendell W. Green, M. D., Toledo; Richard I. Brashear, M. D., Columbus.

6. **MANAGEMENT OF PATIENTS WITH INOPERABLE NEOPLASMS**

Parlors A, B, C, Mezzanine Floor, Deshler-Wallick Hotel

Moderator: Charles M. Barrett, M. D., Cincinnati.

Panel Discussants: Morton Hamburger, Jr., M. D., James H. Mithoefer, M. D., William Germain, M. D., Cincinnati.

3:00 to 3:30 P. M.

RECESS FOR VISITING THE EXHIBITS

TUESDAY, APRIL 19

3:35 P. M.

GENERAL SESSION

Main Ballroom, Mezzanine Floor
Neil House

Louis G. Herrmann, M. D., Cincinnati, Chairman, Committee on Scientific Work, Presiding

3:35 to 4:05

CANCER CONTROL

Charles S. Cameron, M. D., New York, N. Y.

4:10 to 4:40

THE CRIPPLED LUNG

Joseph W. Gale, M. D., Madison, Wis.

4:45 to 5:15

ANESTHESIOLOGY AS AN AID TO DIAGNOSIS AND TREATMENT

Henry S. Ruth, M. D, Philadelphia, Pa.

TUESDAY, APRIL 19

6:00 P. M.

HOUSE OF DELEGATES

DINNER FOR MEMBERS OF THE HOUSE OF DELEGATES AND FIRST BUSINESS SESSION

Hall of Mirrors, Wallick Addition,
Deshler-Wallick Hotel

TUESDAY, APRIL 19

JOINT MEETING OF OBSTETRICAL AND GYNECOLOGICAL SOCIETIES OF CINCINNATI, CLEVELAND AND COLUMBUS

Athletic Club
136 East Broad Street, Columbus

5:30 P. M.

COCKTAIL HOUR

7:00 P. M.

DINNER

THE PSYCHOSOMATIC PROBLEMS OF OBSTETRICS AND GYNECOLOGY

Sprague H. Gardiner, M. D., Indianapolis, Ind.

Tickets at $4.50 each may be obtained in advance from Dr. John H. Holzaepfel, 40 South Third Street, Columbus 15, or at the door.

TUESDAY, APRIL 19

8:00 P. M.

ANNUAL MEETING OF OHIO ACADEMY OF GENERAL PRACTICE

Main Ballroom, Mezzanine Floor
Neil House

Further information concerning the meeting can be obtained from the president of the Academy: Joseph Linder, M. D., 3405 Clifton Ave., Cincinnati 20.

WEDNESDAY, APRIL 20

9:00 A. M.

SECTION ON GENERAL PRACTICE

Main Ballroom, Mezzanine Floor,
Neil House

PROGRAM COMMITTEE

Ross M. Knoble, M. D., Sandusky, Section Chairman
J. G. Lemmon, M. D., Akron, Section Secretary
S. D. Nielsen, M. D., Elyria
L. E. Anderson, M. D., Greentown
Neil Millikin, M. D., Hamilton

9:00 to 9:30

VARIOUS CAUSES OF LOW BACK PAIN AND THEIR MANAGEMENT

Joseph A. Freiberg, M. D., Cincinnati.

9:30 to 9:40

QUESTIONS AND ANSWERS

9:40 to 10:10

CLINICAL SIGNIFICANCE AND MANAGEMENT OF THE HYPASTHENIC PATIENT

Joseph M. Hayman, M. D., Cleveland.

10:10 to 10:20

QUESTIONS AND ANSWERS

10:20 to 11:05

EXAMINATION OF THE HEART FROM THE STANDPOINT OF THE GENERAL PRACTITIONER

Franklin D. Johnston, M. D., Ann Arbor, Mich.

11:05 to 11:15

QUESTIONS AND ANSWERS

11:15 to 11:30

SEGMENTAL NEURALGIA, FIBROSITIS AND MYOSITIS

Joseph Strong, M. D., Elyria.

11:30 to 11:40

QUESTIONS AND ANSWERS

11:40 to 12:00

BUSINESS MEETING

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

WEDNESDAY, APRIL 20

9:00 A. M.

SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Parlors A, B, C, Mezzanine Floor
Deshler-Wallick Hotel

PROGRAM COMMITTEE

Thomas E. Shaffer, M. D., Columbus, Section Chairman
Marion G. Fisher, M. D., Oberlin, Section Secretary
Floyd P. Allen, M. D., Cincinnati
Ollie M. Goodloe, M. D., Columbus
John D. Porterfield, M. D., Columbus

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:45

THE APPRAISAL OF THE HEALTH OF SCHOOL CHILDREN

Thomas E. Shaffer, M. D., Columbus.

9:45 to 12:00

SYMPOSIUM: THE CONTROL OF INFECTIOUS DISEASES IN OHIO

Moderator: John H. Dingle, M. D., Cleveland.

The Infectious Disease Problem in Ohio Today—Paul Q. Peterson, M. D., Columbus.

The Problem of Respiratory Infections—Richard G. Hodges, M. D., Cleveland.

The Problems of Brucellosis and Histoplasmosis—John Prior, M. D., Columbus.

The Problem of Virus Diarrhea—Alex J. Steigman, . M. D., Cincinnati.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

WEDNESDAY, APRIL 20

9:00 A. M.

SECTION ON OBSTETRICS AND GYNECOLOGY

Hall of Mirrors, Wallick Addition
Deshler-Wallick Hotel

PROGRAM COMMITTEE

Richard D. Bryant, M. D., Cincinnati, Section Chairman

Allan C. Barnes, M. D., Columbus, Section Secretary

Ralph K. Ramsayer, M. D., Canton

George M. Wilcoxon, M. D., Alliance

Robert L. Faulkner, M. D., Cleveland

9:00 to 9:15

HYGIENE OF PREGNANCY

Robert F. Daly, M. D., Columbus.

9:15 to 9:30

PREOPERATIVE PREPARATION OF THE GYNECOLOGIC PATIENT

Stuart A. Schloss, M. D., Cincinnati.

9:30 to 9:45

NON-SURGICAL MANAGEMENT OF THE PATIENT WITH CARCINOMA OF THE PELVIS

L. A. Pomeroy, M. D., Cleveland.

9:45 to 10:00

RECESS

10:00 to 10:45

THE CLINICAL SIGNIFICANCE OF NUTRITIONAL DEFICIENCIES IN PREGNANCY

Winslow T. Tompkins, M. D., Philadelphia, Pa.

10:45 to 11:00

BUSINESS MEETING

11:00 to 12:00

PANEL DISCUSSION ON SUBJECTS PRESENTED DURING THE MORNING

Moderator: Richard D. Bryant, M. D., Cincinnati.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

WEDNESDAY, APRIL 20

9:00 A. M.

ANNUAL MEETING OF OHIO STATE RADIOLOGICAL SOCIETY

Private Dining Room No. 4
Mezzanine Floor
Neil House

9:00 to 9:30

ATELECTASIS OF THE NEWBORN

James F. Martin, M. D., Instructor of Radiology Western Reserve University School of Medicine, Cleveland.

9:30 to 9:50

PROBLEMS OF XANTHOMATOUS DISEASE IN CHILDREN

Eugene L. Saenger, M. D., Children's Hospital, Cincinnati.

9:50 to 10:10

CONGENITAL OBSTRUCTION OF THE DUODENUM

Frank M. Barry, M. D. (by invitation), Senior Instructor of Surgery, Western Reserve University School of Medicine, Cleveland.

10:15 to 11:45

ROENTGEN DIAGNOSIS AND TREATMENT OF NEOPLASTIC DISEASE IN CHILDREN

Edward B. D. Neuhauser, M. D., Radiologist, The Children's Medical Center, Boston, Mass.

12:00 Noon

Private Dining Room No. 2

Luncheon for members and guest speakers to be followed by annual business meeting and election of officers.

1:30 P. M.

FILM-READING SESSION

Edward B. D. Neuhauser, M. D., presiding, to be assisted by a group of experts.

WEDNESDAY, APRIL 20

ANNUAL MEETING OF OHIO CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS

Private Dining Room No. 5
Mezzanine Floor
Neil House

William J. Habeeb, M. D., Springfield, President

E. F. Conlogue, M. D., Springfield, Secretary-Treasurer

12:00 Noon

LUNCHEON

PNEUMOPERITONEUM

William J. Habeeb, M. D., and Howard G. Reiser, M. D., Springfield.

EXPERIENCE WITH PAPANICOLAOU TECHNIQUE IN THE DIAGNOSIS OF PULMONARY MALIGNANCIES

Neil C. Andrews, M. D., Walter Baum, M. D., and Karl P. Klassen, M. D., Columbus.

X-RAY CONFERENCE

WEDNESDAY, APRIL 20
1:30 to 3:00 P. M.

INSTRUCTIONAL COURSES
(Admission by Ticket Only)

7. MODERN METHODS OF THERAPY FOR EARLY SYPHILIS

Main Ballroom, Mezzanine Floor, Neil House

Moderator: John D. Porterfield, M. D., Columbus.

Panel Discussants: Roy L. Kile, M. D., Cincinnati; Eldred B. Heisel, M. D., Columbus; L. I. Thomas, M. D., Akron.

8. ACCIDENTS OF LABOR

Private Dining Room No. 3, Mezzanine Floor, Neil House

Moderator: Phillips K. Champion, M. D., Dayton.

Panel Discussants: Glen Keith Folger, M. D., Cleveland; Stanley Thomas Garber, M. D., Cincinnati; Franklin C. Hugenberger, M. D., Columbus; N. E. Wentsler, M. D., Akron.

9. DISEASES OF THE GALLBLADDER

Private Dining Room No. 4, Mezzanine Floor, Neil House

Moderator: Robert T. Allison, Jr., M. D., Akron.

Panel Discussants: George R. Dochat, M. D., Akron; A. P. Ormond, M. D., Akron; Robert M. Bartlett, M. D., Akron.

10. ABDOMINAL EMERGENCIES OF THE NEWBORN

Parlors A, B, C, Mezzanine Floor, Deshler-Wallick Hotel

Moderator: Donald M. Glover, M. D., Cleveland.

Panel Discussants: Frank M. Barry, M. D., Cleveland; Frederick P. Berlin, M. D., Lima; John S. Kiess, M. D., Bucyrus.

11. RHEUMATOID ARTHRITIS

Parlors H, I, J, Wallick Addition, Deshler-Wallick Hotel

Moderator: Robert M. Stecher, M. D., Cleveland.

Panel Discussants: Ralph H. Wolpaw, M. D., Cleveland; Walter M. Solomon, M. D., Cleveland; Shelby G. Gamble, M. D., Cleveland.

12. THE USE OF ANTIBIOTICS IN THE FIELD OF PEDIATRICS

Hall of Mirrors, Wallick Addition, Deshler-Wallick Hotel

Moderator: Charles F. McKhann, M. D., Cleveland.

Panel Discussants: William D. DeVaux, M. D., Cincinnati; Robert P. Ostergard, M. D., Warren; Morris Schaefer, M. D., Cleveland; Robert F. Sylvester, M. D., Columbus.

3:00 to 3:30 P. M.

RECESS FOR VISITING THE EXHIBITS

WEDNESDAY, APRIL 20
3:35 to 5:15 P. M.

MEDICAL TOPICS OF THE DAY

NEW ADVANCES IN HEMATOLOGIC THERAPY

Main Ballroom, Mezzanine Floor, Neil House

Moderator: Charles A. Doan, M. D., Columbus.

Discussants: Richard W. Vilter, M. D., Cincinnati; George M. Guest M. D., Cincinnati; B. K. Wiseman, M. D., Columbus; Robert Heinle, M. D., Cleveland; Foster Myers, M. D., Toledo; Arthur E. Rappaport, M. D., Youngstown.

SURGERY OF THE GASTRO-INTESTINAL TRACT

Hall of Mirrors, Wallick Addition, Deshler-Wallick Hotel

Moderator: Thomas E. Jones, M. D., Cleveland.

Panel Discussants: (To be selected)

ACUTE ARTHRITIS: DIAGNOSIS AND TREATMENT

Parlors A, B, C, Mezzanine Floor, Deshler-Wallick Hotel

Moderator: Marion A. Blankenhorn, M. D., Cincinnati.

Discussants: William A. Altemeier, M. D., Cincinnati; Nathan R. Abrams, M. D., Cincinnati; Robert Lyon, M. D., Cincinnati.

THE RECOGNITION AND MANAGEMENT OF THYROID DISEASE

Parlors H, I, J, Wallick Addition, Deshler-Wallick Hotel

Moderator: George M. Curtis, M. D., Columbus.

Discussants: Louis C. Roettig, M. D., Columbus; William M. Skipp, M. D., Youngstown; Donald M. Glover, M. D., Cleveland; Norris W. Gillette, M. D., Toledo.

ACUTE CARDIORESPIRATORY FAILURE: REQUIREMENTS FOR SUCCESSFUL RESUSCITATION

Private Dining Room No. 4, Mezzanine Floor, Neil House

3:35 to 3:40

1. INTRODUCTION

Claude S. Beck, M. D., Cleveland, Moderator.

3:40 to 4:10

2. RESTORATION OF HEART BEAT

Carl J. Wiggers, M. D., Cleveland.

4:10 to 4:20

3. A NEW MECHANICAL RESPIRATOR—APPARATUS FOR SHOCKING THE HEART

Mr. Kenneth Wolfe, Cleveland.

4:20 to 4:35

4. SUCCESSFUL CASES OF RESUSCITATION FROM CARDIAC ASYSTOLE AND FROM VENTRICULAR FIBRILLATION

Harold Feil, M. D., Cleveland.

4:35 to 4:50

5. CAUSES OF FAILURES IN PATIENTS IN WHOM RESUSCITATION WAS ATTEMPTED

Frank M. Barry, M. D., and Frederick R. Mautz, M. D., Cleveland.

4:50 to 5:00

6. INTRA-ARTERIAL TRANSFUSION

Donald E. Hale, M. D., Cleveland.

5:00 to 5:15

7. EARLY RECOGNITION OF DANGER SIGNALS DURING ANESTHESIA AND CORRECTION OF SAME

Rolland J. Whitacre, M. D., Cleveland.

8. QUESTION-AND-ANSWER PERIOD

WEDNESDAY, APRIL 20

7:30 P. M.

ANNUAL BANQUET

Main Ballroom, Mezzanine Floor
Neil House

MUSIC DANCING
ENTERTAINMENT

THURSDAY, APRIL 21

9:00 A. M.

SECTION ON MEDICINE

Main Ballroom, Mezzanine Floor
Neil House

PROGRAM COMMITTEE

Leon Schiff, M. D., Cincinnati, Section Chairman
Fay A. LeFevre, M. D., Cleveland, Section Secretary
T. P. Sharkey, M. D., Dayton
Phillip T. Knies, M. D., Columbus
Maurice A. Schnitker, M. D., Toledo

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:30

THE USE OF THIOURACIL AND RADIOIODINE IN THE TREATMENT OF THYROTOXICOSIS

E. P. McCullagh, M. D., Cleveland.

9:30 to 10:00

UNIPOLAR LEAD ELECTROCARDIOGRAPHY

Franklin D Johnston, M. D., Ann Arbor, Mich.

10:00 to 10:15

THE CLINICAL ASPECTS OF THROMBO-EMBOLISM

Johnson McGuire, M. D., Cincinnati.

10:15 to 10:45

THE USE OF AMINOPTERIN IN THE TREATMENT OF ACUTE LEUKEMIA

B. K. Wiseman, M. D., Columbus.

10:45 to 11:00

MEDICAL FOLLOW-UP OF VAGOTOMY PLUS GASTRO-ENTEROSTOMY OR PYLOROPLASTY FOR PEPTIC ULCER

E. N. Collins, M. D., Cleveland.

11:00 to 11:15

RESIDUAL HEPATIC DISTURBANCES IN VIRAL HEPATITIS

John R. Neefe, M. D., Philadelphia, Pa.

11:15 to 11:25

RECESS

11:25 to 12:00

PANEL DISCUSSION ON SUBJECTS PRESENTED DURING THE MORNING

Moderator: Leon Schiff, M. D., Cincinnati.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

THURSDAY, APRIL 21

9:00 A. M.

SECTION ON NERVOUS AND MENTAL DISEASES

Parlors H, I, J, Wallick Addition
Deshler-Wallick Hotel

PROGRAM COMMITTEE

Dwight M. Palmer, M. D., Columbus, Section Chairman
John M. Flumerfelt, M. D., Cleveland, Section Secretary
Harrison S. Evans, M. D., Columbus
A. T. Hopwood, M. D., Cambridge
E. O. Harper, M. D., Cleveland

9:00 to 9:45

THE CLINICAL APPLICATION OF THE THEMATIC APPERCEPTION TEST IN DIAGNOSIS AND TREATMENT

J. M. Wittenbrook, M. D., Richard Sidwell, B. S., and Aladar Kandik, B. S., Cleveland.

Discussants: Max L. Lurie, M. D., Cincinnati; Roger A. Gove, M. D., Troy.

9:45 to 10:30

PSYCHOSOMATIC ASPECTS OF EPILEPSY

Henry Lederer, M. D., Cincinnati.

Discussants: James L. Sagebiel, M. D., Dayton; R. E. Pinkerton, M. D., Akron.

10:30 to 10:45

BUSINESS MEETING

10:45 to 11:30

FAILURES IN ELECTROSHOCK THERAPY

Charles L. Anderson, M. D., Worthington.

Discussants: Howard D. Fabing, M. D., Cincinnati; Joseph L. Fetterman, M. D., Cleveland.

11:30 to 12:00

FORAMEN MAGNUM AND HIGH CERVICAL CORD LESIONS SIMULATING DEGENERATIVE DISEASES OF THE CENTRAL NERVOUS SYSTEM

Kenneth H. Abbott, M. D., Columbus.

Discussants: Spencer Braden, M. D., Cleveland; N. R. Hollister, M. D., Dayton.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

THURSDAY, APRIL 21

9:00 A. M.

SECTION ON PEDIATRICS

Parlors A, B, C, Mezzanine Floor
Deshler-Wallick Hotel

PROGRAM COMMITTEE

John Edwin Brown, Jr., M. D., Columbus, Section Chairman

Charles L. Shafer, M. D., Mansfield, Section Secretary
Hugh Wellmeier, M. D., Piqua
George C. Malley M. D., Zanesville
Robert A. Lyon, M. D., Cincinnati

9:00 to 9:15

ERYTHEMA MULTIFORME EXUDATIVUM

Grafton Fanney, M. D., Cleveland.

9:15 to 9:30

HISTOPLASMOSIS: CASE WITH GENERALIZED INVOLVEMENT AND APPARENT RECOVERY

Valerie Friedman, M. D., Columbus.

9:30 to 9:45

CONTROL OF DENTAL CARIES

Paul Kitchin, D. D. S., Columbus.

9:45 to 10:00

HYPOCALCEMIA IN INFANCY

Samuel Rapoport, M. D., Cincinnati.

10:00 to 10:15

ACRODYNIA

Josef Warkany, M. D., and Mr. Donald M. Hubbard, Cincinnati.

10:15 to 10:30

FIBROCYSTIC DISEASE OF THE PANCREAS

Warren Wheeler, M. D., and William Howard, M. D., Columbus.

10:30 to 10:45

TREATMENT OF LEUKEMIA IN CHILDHOOD

Robert Heinle, M. D., Cleveland.

10:45 to 11:00

RECESS

11:00 to 11:30

THE NEWER ANTIBIOTICS

Louis Weinstein, M. D., Boston, Mass.

11:30 to 12:00

PANEL DISCUSSION ON SUBJECTS PRESENTED DURING THE MORNING

Moderator: John Edwin Brown, Jr., M. D., Columbus.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

THURSDAY, APRIL 21

12:00 Noon

HOUSE OF DELEGATES

LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES AND FINAL BUSINESS SESSION

Hall of Mirrors, Wallick Addition
Deshler-Wallick Hotel

THURSDAY, APRIL 21

1:30 to 3:00 P. M.

INSTRUCTIONAL COURSES

(Admission by Ticket Only)

13. PROBLEMS OF PREMATURITY

Room 1337, Deshler-Wallick Hotel

Moderator: J. Victor Greenebaum, M. D., Cincinnati.

Panel Discussants: Allan C. Barnes, M. D., Columbus; Miss Elgie Wallinger, R. N., Columbus; Susan P. Souther, M. D., Columbus; Daniel Jones, M. D., Cincinnati; Gail Englender, M. D., Cincinnati.

14. EVALUATION AND MANAGEMENT OF HYPERTENSION

Private Dining Room No. 4, Mezzanine Floor, Neil House

Moderator: Eugene B. Ferris, M. D., Cincinnati.

Panel Discussants: Morton F. Reiser, M. D., Cincinnati; Robert Taylor, M. D., Cleveland; R. W. Kissane, M. D., Columbus.

15. CIRRHOSIS OF THE LIVER

Main Ballroom, Mezzanine Floor, Neil House

Moderator: A. J. Beams, M. D., Cleveland.

Panel Discussants: Leon Schiff, M. D., Cincinnati; C. Joseph DeLor, M. D., Columbus.

16. DERMATOSES OF INTEREST TO THE GENERAL PRACTITIONER

Parlors H, I, J, Wallick Addition, Deshler-Wallick Hotel

Moderator: Harold N. Cole, M. D., Cleveland.

Panel Discussants: Herbert H. Johnson, Jr., M. D., Cleveland; Eldred B. Heisel, M. D., Columbus; Leon Goldman, M. D., Cincinnati.

17. MANAGEMENT OF THE UNCONSCIOUS PATIENT

Private Dining Room No. 2, Mezzanine Floor, Neil House

Moderator: Max T. Schnitker, M. D., Toledo.

Panel Discussants: Howard D. Fabing, M. D., Cincinnati; Frederick S. Coombs, M. D., Youngstown; Ralph L. Zucker, M. D., Toledo.

18. INFANT FEEDING

Parlors A, B, C, Mezzanine Floor, Deshler-Wallick Hotel

Moderator: A. A. Weech, M. D., Cincinnati.

Panel Discussants: Katharine Dodd, M. D., and Bernard D. Gillman, M. D., Cincinnati.

3:00 to 3:30 P. M.

RECESS FOR VISITING THE EXHIBITS

THURSDAY, APRIL 21

3:35 P. M.

GENERAL SESSION

Main Ballroom, Mezzanine Floor
Neil House

Charles A. Doan, M. D., Columbus, Member, Committee on Scientific Work, Presiding

3:35 to 4:05

PSYCHIATRIC ASPECTS OF MEDICINE

Kenneth E. Appel, M. D., Philadelphia, Pa.

4:10 to 4:40

DIAGNOSIS AND TREATMENT OF EARLY POLIOMYELITIS

Philip M. Stimson, M. D., New York, N. Y.

4:45 to 5:15

RECENT DEVELOPMENTS IN VIRAL HEPATITIS AND OTHER LIVER DISEASES

John R. Neefe, M. D., Philadelphia, Pa.

THURSDAY, APRIL 21

8:00 P. M.

GENERAL SESSION

Main Ballroom, Mezzanine Floor
Neil House

"INFORMATION PLEASE"

Informal question-and-answer period and panel discussions on the activities and operations of the Ohio Industrial Commission, Ohio Department of Public Welfare, and Ohio Department of Health, including school health and rural health programs, as they relate to the day-by-day practice of the physician. Opportunity will be offered for questions from the floor. This innovation will provide the audience with pertinent facts about the medical activities of agencies with which physicians deal daily in their practice.

Moderator: Mr. Charles S. Nelson, Executive Secretary, Ohio State Medical Association.

8:00 to 8:40

OHIO INDUSTRIAL COMMISSION

Panel participants:

Mr. George L. Coffinberry, Chairman, Ohio Industrial Commission;

R. M. Andre, M. D., Supervisor, Medical Section, Ohio Industrial Commission;

Mr. George H. Thompson, Supervisor, Claims Section, Ohio Industrial Commission;

H. P. Worstell, M. D., Chairman, Committee on Industrial Health and Workmen's Compensation, Ohio State Medical Association.

8:40 to 9:20

OHIO DEPARTMENT OF PUBLIC WELFARE

Panel participants:

Judge Henry J. Robison, Assistant Director, Ohio Department of Public Welfare;

Mr. Robert B. Canary, Acting Chief, Division of Social Administration, Ohio Department of Public Welfare;

Mr. Lauren A. Glosser, Examiner, Division of Aid for the Aged, Ohio Department of Public Welfare.

9:20 to 10:00

OHIO DEPARTMENT OF HEALTH:

Panel participants:

John D. Porterfield, M. D., Director, Ohio Department of Health;

Carl A. Wilzbach, M. D., Health Director, City of Cincinnati, and Chairman, Committee on Education, Ohio State Medical Association;

Thomas E. Shaffer, M. D., Coordinator on School Health, Ohio State University, Member, Committee on School Health, Ohio State Medical Association, and School Physician, University School, Ohio State University;

Carll S. Mundy, M. D., Chairman, Committee on Rural Health, and Member of The Council, Ohio State Medical Association, Member, Committee on Rural Health, American Medical Association.

FRIDAY, APRIL 22

9:00 A. M. to 12:00 Noon

ROUND-TABLE DISCUSSIONS

INDUSTRIAL TOXICOLOGY

Parlors H, I, J, Wallick Addition, Deshler-Wallick Hotel

Moderator: Robert A. Kehoe, M. D., Cincinnati.

Discussants: (To be selected)

PRE-ECLAMPSIA AND ECLAMPSIA

Private Dining Room No. 4, Mezzanine Floor, Neil House

Moderator: Allan C. Barnes, M. D., Columbus.

Discussants: Hans Schlumberger, M. D., Columbus; John Fleming, M. D., Cincinnati; Marion Black, M. D., Cleveland; Charles Hendricks, M. D., Columbus.

ALLERGY FOR THE GENERAL PRACTITIONER

Main Ballroom, Mezzanine Floor, Neil House

Moderator: Jonathan Forman, M. D., Columbus.

Discussants: William Mitchell, M. D., Columbus; Milton Cohen, M. D., Cleveland; Karl D. Figley, M. D., Toledo.

CURRENT TRENDS IN TREATMENT OF DIABETES MELLITUS

Parlors A, B, C, Mezzanine Floor, Deshler-Wallick Hotel

Moderator: George M. Guest, M. D., Cincinnati.

Discussants: Cecil Striker, M. D., Cincinnati; Arthur Mirsky, M D., Cincinnati; E. P. McCullagh, M. D., Cleveland; Henry J. John, M. D., Cleveland; T. P. Sharkey, M. D., Dayton.

CARDIOVASCULAR RENAL DISEASE: NEWER DEVELOPMENTS IN DIAGNOSIS AND TREATMENT

Hall of Mirrors, Wallick Addition, Deshler-Wallick Hotel

Moderator: Roy W. Scott, M. D., Cleveland.

Discussants: (To be selected)

THE JAUNDICED PATIENT

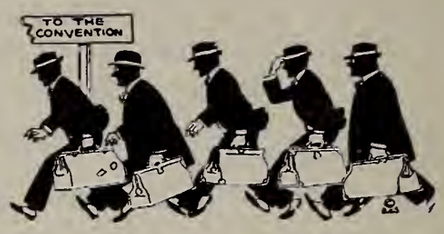
Private Dining Room No. 2, Mezzanine Floor, Neil House

Moderator: Frank M. Barry, M. D., Cleveland.

Discussants: Phillip F. Partington, M. D., Cleveland; Austin Chinn, M. D., Cleveland; Leon Schiff, M. D., Cincinnati; Claude Starr-Wright, M. D., Columbus; C. Joseph Delor, M. D., Columbus.

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1949 ANNUAL MEETING



OHIO STATE MEDICAL ASSOCIATION

Columbus, Ohio — April 19 - 20 - 21 - 22

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VIRGINIA, Third and Gay Sts.	$3.00-4.00	$4.50- 5.50	$6.00- 7.00
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You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 19, 20, 21, 22, 1949, or for such other period as may be indicated herein.

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SCIENTIFIC EXHIBITS

THE Scientific Exhibit in the Main Ballroom, Mezzanine Floor, Deshler-Wallick Hotel, will be open daily from 9:00 A. M. to 6:00 P. M. on Tuesday, April 19, Wednesday, April 20, and Thursday, April 21; and from 9:00 A. M. to 12:00 Noon on Friday, April 22.

Booth No.

APPLICATION OF INTRACARDIAC CATHETERIZATION IN THE DIAGNOSIS OF CONGENITAL HEART DISEASE — 1

Dr. Roy W. Scott and Dr. Harry A. Zimmerman, Cleveland City Hospital, Cleveland; Department of Medicine, Western Reserve University, City Hospital Division

CANCER OF THE COLON — 4

Dr. Paul I. Hoxworth and Dr. Bruce K. MacMillan, Department of Surgery, University of Cincinnati, Cincinnati General Hospital

CEREBRAL PALSY: CAUSAL FACTORS AND TREATMENT — 6

Ohio Society for Crippled Children, Inc., Columbus

DICUMAROL TREATMENT AND PROTHROMBIN TEST — 7

Dr. John W. Martin, University Hospitals, Cleveland

EARLY DIAGNOSIS OF CANCER OF THE UTERUS 8

Dr. George M. Wilcoxon, University Hospitals, Western Reserve University, Cleveland

OPERATIVE CHOLANGIOGRAPHY — 9

Dr. Philip F. Partington and Dr. M. D. Sachs, Crile V. A. Hospital and Western Reserve University School of Medicine, Cleveland

SPINAL ANESTHESIA — 11

Dr. B. B. Sankey, Cleveland, Dr. George F. Collins, Columbus, Dr. E. P. Knisely, Worthington, and Dr. J. J. Jacoby, Columbus, Ohio Society of Anesthesiologists

NON-TUBERCULOUS PULMONARY CALCIFICATIONS: RELATIONSHIPS TO FUNGUS INFECTIONS — 12

Dr. John A. Prior, Department of Medicine, Ohio State University, and Dr. John W. Wilce and Dr. William Palchanis, Student Health Service, Ohio State University, Columbus

PLANNED PARENTHOOD LEAGUE AND THE PRACTICING PHYSICIAN — 13

Dr. Allan C. Barnes, Columbus, Planned Parenthood League of Ohio

BRAIN TUMORS — 14

Dr. H. E. Lefever, Dr. R. S. Fidler, White Cross Hospital, Columbus

ARTERIOSCLEROSIS IN DIABETES — 15

Dr. Joseph I. Goodman, Cleveland Diabetes Society, Cleveland

Booth No.

PLASTIC AND RECONSTRUCTIVE SURGERY — 16

Dr. Clifford L. Kiehn, Plastic Surgery Section of the Department of Surgery, School of Medicine, Western Reserve University, Cleveland

CIRCULATORY CHANGES DURING ANESTHESIA — 17

Dr. J. J. Jacoby, Department of Anesthesia, Ohio State University, Columbus

PNEUMO-ARTHROGRAPHY OF THE KNEE — 18

Dr. W. H. McGaw, Dr. M. D. Sachs and Dr. J. M. Muckley, Department of Orthopedic Surgery and Radiology, Crile V. A. Hospital and Western Reserve University Hospitals and Medical School, Cleveland

BIOPSY OF DIFFUSE PULMONARY LESIONS — 20

Dr. Karl P. Klassen, Dr. John Anlyan and Dr. George M. Curtis, Department of Research Surgery, Ohio State University, Columbus

SURGICAL NUTRITION — 21

Dr. Edwin H. Ellison and Dr. Clarke Case, Department of Surgery, Ohio State University, Columbus

DEFINITIVE CARE OF THE ACUTE HAND INJURY — 24

Dr. James M. Shaffer, Dayton

DIAGNOSTIC CEREBRAL ANGIOGRAPHY — 26

Dr. Spencer Braden and Dr. Richard C. Schneider, University Hospital, Ann Arbor, Michigan; St. Luke's Hospital, St. Vincent's Charity Hospital and Marine Hospital, Cleveland

CARCINOMA OF THE TONGUE — 27

Dr. Arthur James, Department of Surgery, Ohio State University, Columbus

COMMON CONGENITAL AND ACQUIRED DEFORMITIES — 28

Dr. Bruce Martin, Department of Surgery, Ohio State University, Columbus

MANAGEMENT OF UPPER GASTRO-INTESTINAL HEMORRHAGE — 29

Dr. Stanley O. Hoerr, Dr. C. Joseph DeLor, Dr. Floyd Beman and Dr. Robert M. Zollinger, Departments of Medicine and Surgery, Ohio State University, Columbus

CLINICAL APPLICATION OF STERNAL MARROW BIOPSY — 30

Dr. Austin S. Weisberger and Dr. Robert W. Heinle, University Hospitals and School of Medicine, Western Reserve University, Cleveland

Booth No.

BERYLLIUM 31

Dr. R. A. Kehoe, Dr. Frank R. Dutra and Mr. E. J. Largent, Kettering Laboratory of Applied Physiology, College of Medicine, University of Cincinnati, Cincinnati

CRIMINAL ABORTION 32

Dr. Herbert P. Lyle, Coroner, Hamilton County, and Dr. Frank R. Dutra, Kettering Laboratory of Applied Physiology, College of Medicine, University of Cincinnati

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Dr. Hans G. Schlumberger, Department of Pathology, Ohio State University, Columbus

IDIOPATHIC SCOLIOSIS 34

Dr. Willis T. Kubiac and Dr. Henry B. Lacey, Department of Orthopedic Surgery, Ohio State University, Columbus

PLASTIC SURGERY 36

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Dr. Joseph E. Brown, Cleveland

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Dr. Emmerich von Haam, Dr. W. Baum, Dr. D. Eshbaugh, Dr. T. Montgomery and Dr. R. Williams, Department of Pathology, Ohio State University, Columbus

MALE FROG PREGNANCY TEST (Wiltberger-Miller) 39

Dr. Wynne Silbernagel, Dr. Robert Pickett, Mr. Emil Massa and Mr. Carl Brandfass, Department of Obstetrics, White Cross Hospital, Columbus; Department of Biological Sciences, Denison University, Granville

PAPANICOLAOU TEST IN THE EARLY DIAGNOSIS OF CANCER: AN ACADEMY OF MEDICINE PLAN 40

The Academy of Medicine of Toledo and Lucas County, Toledo

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Dr. Herbert H. Johnson, Jr., Department of Dermatology and Syphilology, Western Reserve University School of Medicine, Cleveland; Dr. Eldred B. Heisel, Department of Dermatology and Syphilology, Ohio State University College of Medicine, Columbus; and Dr. Leon Goldman, Department of Dermatology and Syphilology, University of Cincinnati College of Medicine, Cincinnati

THE ACUTE LEUKEMIAS 42

Dr. Charles A. Doan, Dr. Bruce K. Wiseman and Dr. Claude Starr-Wright, Department of Medicine, Ohio State University, Columbus

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Dr. Max T. Schnitker, Dr. Maurice Schnitker, Dr. George T. Booth, Toledo

Booth No.

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Dr. D. E. Hale, Cleveland Clinic, Cleveland

DIAGNOSTIC AIDS AND BULBAR POLIOMYELITIS 45

National Foundation for Infantile Paralysis, Inc., Franklin D. Roosevelt, Founder, New York

PRECOCIOUS PUBERTY IN CHILDREN 46

Dr. Parke G. Smith, Dr. Joseph Warkany and Dr. Arthur T. Evans, Departments of Urology and Pediatrics, Children's Hospital, Cincinnati General Hospital, University of Cincinnati College of Medicine, Cincinnati

PREVENTIVE MEDICAL PROBLEMS IN OHIO 47

Ohio Department of Health

Ohio Doctors To Lead at Allergists Meeting, Chicago, April 14-17

Several Ohio physicians will take leading roles in the Annual Meeting of the American College of Allergists at the Palmer House, Chicago, Thursday, April 14, to Sunday, April 17, inclusive. Registration will begin Thursday at 2 p. m. All those interested in allergy, as well as members, are invited.

There will be a meeting of the Board of Directors and the Board of Regents, as well as the various committees, on Thursday beginning at 9 a. m.

Those attending are invited to bring their wives. Plans have been made for the ladies to attend the Breakfast Club Radio Broadcast from 8 to 9 a. m., Saturday, and a complimentary luncheon and fashion show to be held at Marshall Fields on the same day.

Dr. John H. Mitchell, Columbus, is program committee chairman, and has arranged a well-rounded two-day scientific program. Educational features also will include a Scientific Exhibit presented in 20 sections and a Technical Exhibit in which 40 exhibitors will be represented.

Dr. George E. Rockwell of Cincinnati will preside as president of the College during the business session Saturday afternoon. A cocktail hour Saturday evening will be followed by an informal banquet and evening of dancing.

Dr. Jonathan Forman, Editor of *The Journal*, will assume office as president at this meeting. Dr. Forman was named president-elect at the annual meeting last year in New York.

On Sunday afternoon there will be a panel discussion on pediatric allergy under direction of Dr. Bret Ratner. Those attending are requested to make their hotel reservations directly with the Palmer House where a block of rooms has been reserved.

TECHNICAL EXHIBITORS

MEZZANINE LOUNGE AND JUNIOR BALLROOM, NEIL HOUSE

Open from 9:00 A. M. to 6:00 P. M. on Tuesday, April 19; Wednesday, April 20; Thursday, April 21; and from 9:00 A. M. to 12:00 Noon, Friday, April 22

Exhibitor	Address	Booth No.
Abbott Laboratories	North Chicago, Ill.	45
Aloe Company, A. S.	St. Louis, Mo.	32
Ames Company, Inc.	Elkhart, Ind.	9
Ayerst, McKenna & Harrison, Ltd.	New York, N. Y.	33
Baker Laboratories, Inc., The	Cleveland, Ohio	14
Barlow-Maney Laboratories, Inc.	Cedar Rapids, Iowa	62
Beech-Nut Packing Company	Canajoharie, N. Y.	10
Borden Company, The	New York, N. Y.	42
Bowman Bros. Drug Co., The	Canton, Ohio	39
Burke-Garinger X-Ray Sales Co.	Cleveland, Ohio	15
Burroughs Wellcome & Co. (U.S.A.) Inc.	Tuckahoe, N. Y.	68
Camel Cigarettes	New York, N. Y.	46, 47
Cameron Surgical Specialty Co.	Chicago, Ill.	4
Camp & Company, S. H.	Jackson, Mich.	41
Carnation Company	Oconomowoc, Wis.	64
Ciba Pharmaceutical Products, Inc.	Summit, N. J.	58
Coca-Cola Company, The	Atlanta, Georgia	36, 37
Columbus Hospital Supply Co.	Columbus, Ohio	12, 13
DePuy Manufacturing Company	Warsaw, Ind.	7
Electro Medical Equipment Co.	Cleveland, Ohio	23
Endocrine Company	Union City, N. J.	59
Endo Products Inc.	Richmond Hill, N. Y.	57
Fisher & Company, H. G.	Franklin Park, Ill.	52
General Electric X-Ray Corporation	Cleveland, Ohio	50, 51
Gerber Products Company	Fremont, Mich.	67
Heinz Company, H. J.	Pittsburgh, Pa.	63
Holland-Rantos Company, Inc.	New York, N. Y.,	21
"Junket" Brand Foods	Little Falls, N. Y.	40
Kelley-Koett Manufacturing Company, The	Covington, Ky.	29, 30
Lea & Febiger	Philadelphia, Pa.	5
Lederle Laboratories Division, American Cyanamid Co.	New York, N. Y.	16
Liebel-Flarsheim Company, The	Cincinnati, Ohio	28
Lilly and Company, Eli	Indianapolis, Ind.	34
Mead Johnson & Company	Evansville, Ind.	2
Medical Protective Company, The	Fort Wayne, Ind.	25
Merrell Company, Wm. S., The	Cincinnati, Ohio	43
Mosby Company, C. V., The	St. Louis, Mo.	24
M & R Dietetic Laboratories, Inc.	Columbus, Ohio	27
Ortho Pharmaceutical Corporation	Raritan, N. J.	17
Parke, Davis & Company	Detroit, Mich.	60
Pet Milk Sales Corporation	St. Louis, Mo.	31
Philip Morris & Co., Ltd., Inc.	New York, N. Y.	53
Picker X-Ray Corporation	New York, N. Y.	65, 66
Safety First Supply Company	Pittsburgh, Pa.	8
Saunders Company, W. B.	Philadelphia, Pa.	18
Schering Corporation	Bloomfield, N. J.	1
Schuemann-Jones Co., The	Cleveland, Ohio	44
Searle & Co., G. D.	Chicago, Ill.	49
Sharp & Dohme, Inc.	Philadelphia, Pa.	26
Spencer, Incorporated	New Haven, Conn.	61
Squibb & Sons, E. R.	New York, N. Y.	3
Templar-Thelen X-Ray Company	Cincinnati, Ohio	35
U. S. Vitamin Corporation	New York, N. Y.	6
Warren-Teed Products Company, The	Columbus, Ohio	48
Wendt-Bristol Company	Columbus, Ohio	22
Westinghouse Electric Corporation	Pittsburgh, Pa.	55, 56
White-Haines Optical Company	Columbus, Ohio	38
White Laboratories, Inc.	Newark, N. J.	20
Winthrop-Stearns Inc.	New York, N. Y.	19
Wocher & Son Company, Max, The	Cincinnati, Ohio	54
Wyeth, Incorporated	Philadelphia, Pa.	11

Short Polio Courses Scheduled In Cleveland for Summer

Short training courses in poliomyelitis will be given this year at the Department of Contagious Diseases, City Hospital, Cleveland, under the direction of Dr. John A. Toomey, director of the Poliomyelitis Teaching and Training Center. The dates are July 18-23, August 8-13, and August 29-September 3.

These courses have been aided by a grant given by the National Foundation for Infantile Paralysis to Western Reserve University. The Foundation will pay the expenses of the enrollee, providing the chairman of his local chapter approves. Meals may be purchased at the hospital at a nominal cost, but each enrollee is responsible for his own hotel reservations. There is no tuition fee

There also will be courses for nurses and physical therapists. Complete programs and application blanks may be secured by writing to Dr. Toomey at City Hospital.

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	S. J. Ellison	R. L. Lawwill
BROWN		
BUTLER	C. T. Atkinson	D. M. Blizzard
	H. M. Lowell	J. F. Borelli
CLERMONT	G. E. Rockwell	J. M. Coleman
CLINTON	Edmond K. Yantes	R. R. Buchanan
HAMILTON	William A. Altemeier	Daniel E. Earley
	C. R. Deeds	John W. Hauser
	Harry L. Fry	Richard B. Homan
	Edward J. McGrath	Daniel V. Jones
	Stanley D. Simon	Robert H. Kotte
	Arthur W. Wendel	Charles H. Moore
	Joseph Lindner	H. J. Nimitz
	Richard D. Bryant	C. R. Rittershofer
	Emil R. Swepston	Robert M. Woolford
HIGHLAND	J. Martin Byers	John G. Anderson
WARREN	O. L. Layman	J. A. Nock
SECOND DISTRICT		
CHAMPAIGN	D. C. Houser	E. R. Earle
CLARK	Ray M. Turner	L. H. Mendelsohn
DARKE	J. E. Gillette	C. E. Geckler
GREENE	C. G. McPherson	P. D. Espey
MIAMI	G. A. Woodhouse	B. M. Hogle
MONTGOMERY	M. D. Prugh	L. E. Baker
	R. D. Dooley	N. D. Shepard
	R. S. Binkley	R. C. Doan
	A. W. Carley	R. E. Pumphrey
PREBLE		
SHELBY	Russell L. Wiessinger	H. E. Crimm
THIRD DISTRICT		
ALLEN	Fred P. Berlin	M. D. Soash
AUGLAIZE	R. C. Hunter	Elizabeth Y. Kuffner
CRAWFORD	John S. Kiess	J. W. Arnold
HANCOCK	Frank M. Wiseley	Lena S. Enright
HARDIN	Floyd M. Elliott	W. D. Dewar
LOGAN	Hobart L. Mikesell	Warren F. Mills
MARION	A. E. Morrison	Robert T. Gray
MERCER	E. J. McLaughlin	M. G. Harnick
SENECA	R. F. Machamer	Paul J. Leahy
VAN WERT	Roy E. Shell	T. L. Edwards
WYANDOT	C. B. Schoolfield	F. M. Smith
FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	Paul B. Newcomb
FULTON	R. E. Merrill	E. R. Murbach
HENRY	B. L. Johnson	Thomas W. Quinn
LUCAS	A. L. Bershon	H. L. Hauman
	O. E. Todd	T. C. Kiess
	E. E. Lyon	J. W. Erkert
	R. Kuebbeler	D. C. Frick
	R. A. Diethelm	C. R. Forrester
OTTAWA	G. A. Boon	Cyrus R. Wood
PAULDING	Ray Mouser	K. C. Evans
PUTNAM	W. B. Recker	M. W. Palestrant
SANDUSKY	H. L. Keiser	W. E. Brown
WILLIAMS	H. W. Wertz	H. R. Mayberry
WOOD	Paul F. Orr	Frank V. Boyle
FIFTH DISTRICT		
ASHTABULA	P. J. Collander	H. A. Tagett
CUYAHOGA	D. A. Chambers	A. C. J. Brickel
	C. G. LaRocco	Michael Geraci
	J. H. Budd	J. W. Conwell
	D. C. Darrah	P. A. Mielcarek
	H. B. Wright	J. M. Rossen
	C. L. Hudson	I. L. Schonberg
	J. H. Lazzari	W. E. Smith
	J. T. Ledman	Walter Zeiter
	F. A. LeFevre	E. F. Schroeder
	J. D. Osmond, Jr.	E. A. Marshall
	George Tischler	W. F. Boukalik
	R. R. Renner	F. A. Spittler
	R. J. Whitacre	
GEAUGA	Phillip P. Pease	Alton W. Behm
LAKE	Morris G. Carmody	B. S. Park

Counties	Delegates	Alternates
SIXTH DISTRICT		
COLUMBIANA	P. H. Beaver	J. A. Fraser
MAHONING	E. J. Wenaas	R. E. Odom
	I. C. Smith	W. J. Tims
	Wm. M. Skipp	J. C. Vance
PORTAGE	R. C. Neely	Elizabeth A. Leggett
STARK	L. E. Anderson	A. E. Boyles
	R. K. Ramsayer	Harry Beck
	C. C. Couch	G. M. Wilcoxon
SUMMIT	R. E. Pinkerton	R. M. Bartlett
	Kurt Weidenthal	M. F. Bossart
	L. A. Witzeman	L. E. Brown, Jr.
	E. W. Burgner	F. A. Smith
TRUMBULL	E. G. Kyle	S. J. Shapiro
SEVENTH DISTRICT		
BELMONT	D. Myers Creamer	Harvey H. Murphy
CARROLL	S. L. Weir	Glenn C. Dowell
COSHOCTON	E. J. Booth	G. W. Stelzner
HARRISON	Carl F. Goll	Gerald Vorhies
JEFFERSON	Max H. Rosenblum	John Y. Bevan
MONROE		
TUSCARAWAS	J. S. Adler	Edgar C. Davis, Jr.
EIGHTH DISTRICT		
ATHENS	P. J. Woodworth	A. A. Baldwin
FAIRFIELD	L. E. Stenger	W. M. Kuntz
GUERNSEY	Robert A. Ringer	J. D. Knapp
LICKING	George A. Gressle	Dale E. Roth
MORGAN	A. A. Coulson	Henry Bachman
MUSKINGUM	George C. Malley	Paul Jones
NOBLE	Edward G. Ditch	C. F. Thompson
PERRY	James Miller	Edgar D. Allen
WASHINGTON	Kenneth E. Bennett	Donald S. Williams
NINTH DISTRICT		
GALLIA	Charles E. Holzer, Jr.	N. H. Foster
HOCKING	C. T. Grattidge	H. G. Southard
JACKSON	Earl J. Levine	C. C. Fitzpatrick
LAWRENCE	Wm. Ray Swango	Geo. G. Hunter
MEIGS	R. E. Boice	John Philson
PIKE	Paul H. Jones	W. L. McCaleb
SCIOTO	W. A. Quinn	L. Dow Allard
VINTON	H. D. Chamberlain	
TENTH DISTRICT		
DELAWARE	E. V. Arnold	J. G. Parker
FAYETTE	J. H. Persinger	Hugh Payton
FRANKLIN	Grant O. Graves	H. R. Mitchell
	Warren G. Harding, 2nd	Thomas E. Rardin
		A. Ruppersburg, Jr.
	Charles W. Pavey	George F. Collins
	F. C. Hugenberger	William L. Pritchard
	Phillip T. Knies	Clark P. Pritchett
	Richard L. Meiling	
KNOX	R. S. Lord	H. T. Lapp
MADISON	E. S. Crouch	Sol Maggied
MORROW	J. P. Ingmire	Charles S. Jackson
PICKAWAY	E. S. Shane	M. D. Gamble
ROSS	Ralph W. Holmes	O. P. Tatman
UNION	E. J. Marsh	F. C. Callaway
ELEVENTH DISTRICT		
ASHLAND	G. D. Fridline	W. C. Smith
ERIE	Ross M. Knoble	V. A. Killoran
HOLMES	N. P. Stauffer	A. J. Earney
HURON	O. J. Nicholson	Wm. H. Kauffman
LORAIN	George A. Hoke	Geo. D. Nicholas
	A. C. Siddall	Theodore Berg
MEDINA	R. F. Fasoli	G. T. Wagner
RICHLAND	P. A. Blackstone	
WAYNE	Lyman A. Adair	H. G. Beeson

OFFICERS

Pres.	A. A. Brindley	Treas.	H. P. Worstell
Pres.-Elect.	Carl A. Lincke	Past-Pres.	R. L. Rutledge

COUNCILORS

District		District	
First	E. O. Swartz	Seventh	R. J. Foster
Second	H. C. Messenger	Eighth	Chester P. Swett
Third	J. Craig Bowman	Ninth	J. P. McAfee
Fourth	Carll S. Mundy	Tenth	H. M. Clodfelter
Fifth	Fred W. Dixon	Eleventh	John S. Hattery
Sixth	Paul A. Davis		

Auxiliary's Annual Meeting . . .

Wives of Physicians Urged To Attend Business and Social Functions Concurrent with Annual Meeting of Ohio State Medical Association

THE wives of all physicians attending the Annual Meeting of the Ohio State Medical Association are urged to attend both the business sessions and the social functions being planned for the Ninth Annual Meeting of the Auxiliary, April 19, 20 and 21.

General Chairman of the Annual Meeting Committee is Mrs. Donald J. Alspaugh, Columbus, with Mrs. Wayne Brehm, also of Columbus, as co-chairman.

Auxiliary Headquarters and Registration Booth will be in the Seneca Hotel, Columbus.

Full details of the Convention are on page 3 in the March issue of *Medical Auxiliary News*.

PROGRAM

TUESDAY, APRIL 19

9:30 A. M. Pre-Convention Board Meeting, Gold Room, Seneca Hotel.

12:00 Noon Luncheon—Board of Directors, Blue Room, Seneca Hotel.

1:30 P. M. Formal Opening Session, Auxiliary Members and House of Delegates, Ballroom. Mrs. E. Benjamin Gillette, Toledo, president, will preside. Reports of Officers and Reports of Chairmen of Standing Committees will be received.

4:00 P. M. Tea, honoring Mrs. A. A. Brindley, Toledo; Mrs. Wayne Brehm, Columbus, president of the Franklin County Auxiliary; and the past-presidents of the State of Ohio.

A musical program will be presented by Capital University Chapel Choir with Ellis E. Snyder, directing.

WEDNESDAY, APRIL 20

9:30 A. M. Second Session. Auxiliary Members and House of Delegates, Blue and Gold Room. Reports of Special Committees and Reports of County Presidents will be received.

12:00 Noon "In Memoriam," Mrs. George Cooperrider.

1:00 P. M. Presidents' Luncheon, Ballroom, honoring Mrs. E. Benjamin Gillette, state president; Dr. A. A. Brindley, President, Ohio State Medical Association; visiting state presidents, presidents-elect and Advisory Council, Ohio State Medical Association. Guest speaker—Mr. Arthur Conrad.

3:00 P. M. Discussion Groups led by State Officers and Chairmen of Standing Committees.

7:30 P. M. Annual Banquet of the Ohio State Medical Association. Ballroom—The Neil House.

THURSDAY, APRIL 21

9:30 A. M. Third Session, Blue and Gold Room—Auxiliary Members and House of Delegates. Mrs. E. Benjamin Gillette will preside. Election and Installation of officers—Inaugural Address, Mrs. C. W. Kirkland, Bellaire.



Working on plans for the Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association are Mrs. Donald J. Alspaugh (right), general chairman, and Mrs. Wayne Brehm, co-chairman, of the arrangements committee.

O. S. M. A. Staff Photo.

1:00 P. M. Luncheon, Ballroom, honoring Mrs. Kirkland and Officers; Dr. Carl A. Lincke, president-elect, Mr. Charles S. Nelson, executive secretary, Mr. George H. Saville, director of public relations, Ohio State Medical Association; also Mrs. Luther D. Kice, national president of the Woman's Auxiliary. A style show will precede adjournment.

Immediately following adjournment there will be a Post-Convention Board Meeting in the Blue Room with Mrs. C. W. Kirkland presiding.

On the Firing Line . . .

Shots At Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"AMERICAN medicine has advanced amazingly in the past 25 years. We now have the best medicine in the world in America. It required 2,000 years to increase the average length of life from 24 years to 49 years. In less than 50 years it has been further increased in this country to 67 years. . . . This increase has not yet shown any tendency to stop . . .

"But Mr. Ewing now asks us to abandon a pattern of medical practice that is accomplishing nothing less than miracles, and to adopt a pattern of medical practice which has resulted in a lowering of medical standards wherever it has been tried."—*Dr. Paul R. Hawley, executive officer of the Blue Cross and Blue Shield voluntary prepayment hospital and medical care plans.*

* * *

"Arguments to adopt the British plan (to socialize the legal profession) in this country will be powerful, and local bar associations will be well advised to prepare for the onslaught. The left wing of the triumphant Democratic party is thirsting for new forms of what it calls 'socialization.' It conceives the election to have been a mandate to continue the march toward statism."—*Raymond Moley in the Columbus Dispatch.*

* * *

"The living power of medicine, resident as it must always be in the personnel of the profession, has passed out of its hands to be lost, for a time, in the dead machinery of the bureau."—*Lord Horder, London, England, regarding the British Compulsory Health Insurance Plan.*

* * *

". . . Whereas, it is still our conviction that any compulsory health insurance plan—political medicine—destroys the essential personal relationship between patient and the doctor of his choice and increases Government supervision and control of our private lives and is in full substance and effect—the planned economy of a collectivist nature—and

"Whereas, the Communists have proclaimed 'socialized medicine as the keystone in the arch of a socialized state" . . .

"Now therefore be it resolved, by the American Legion in Convention assembled in Miami, Florida, this 18th, 19th, 20th, and 21st of October, 1948, that we are still unalterably opposed to all efforts and movements to enforce socialized medicine upon the American people."—*Resolution Adopted.*

* * *

"The President speaks favorably of American capitalism and the free enterprise system and then proceeds to show how effectively it can be undermined—something which should please Uncle Joe Stalin, who is betting on the inroads of socialism into the American economic system and the weakening of that structure."—*David Lawrence, commenting in The Columbus Dispatch on the 'State of the Union' message.*

* * *

"The problem of eliminating politics from government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system . . . compulsory insurance would inject the government into the relationship between practitioner and patient. A real danger exists that government actions would impair that relationship and hence the quality of medical care."—*Conclusions of the Brookings Institution on the Issue of Compulsory Health Insurance, 1948.*

* * *

". . . Historically, everytime and everywhere in the world that government has instituted socialized medicine, it has resulted in the complete and total degeneration and destruction of the medical system in that country.

"What is worse, the ultimate result, as in England today, with its panel system, is that the people do not get good medical care at all, but are brushed off and handled by the government doctors as you'd dip sheep on a big ranch.

"And the only people who benefit in the final analysis are the patronage appointees, who get jobs on the government payroll, handling the red tape . . ."—*Fulton Lewis, Jr.*

* * *

"Now, I'm no Doctor. But as I see the principles involved it goes even deeper than Doc-

CLIP THIS MATERIAL FOR REFERENCE

tors. A Doctor is an American citizen. His individual rights are no less important because he is outnumbered. This republic is obligated to protect the minority.

"It is fully as obligated to protect the minority as it is to respect the majority. A Doctor may work a lifetime to secure independence as may any enterprise. What legal right has Mr. Ewing or anybody else to tell a Doctor where he will work, in what community, or why he will practice medicine, how much or how little he is to learn, what he is to charge for his talents, whom he is to treat, and where he is to treat them?"—*Henry J. Taylor on General Motors Broadcast.*

* * *

"Payroll deductions were foremost in many minds when they considered the proposed national medical care plan. Typical comment: 'If it means more pay deductions, then I'm against it. . . . Before Congress cuts deeper into my pay check, a thorough report should be given to the public.' "—*Comments to William Bebout, Poll Director, The Cleveland Press.*

* * *

"The first reaction of the public was to welcome the Act, for the man in the street thought that all these services were going to be provided free whenever he wanted medical advice. There is already a strong current in the opposite direction; the busy man cannot wait hours in queues to receive scant time and attention from his doctor when his turn does come. Such patients are therefore asking their general practitioners to see them on a private basis, or they are going to the G. P.'s who are not in the Scheme.—*S. C. Warner, M. D., London, Secretary, Fellowship for Freedom in Medicine.*

* * *

"The Life Insurance Association of America has reported that more than 52,000,000 people, or well over one-third of the total population of the U. S. are protected under some form of voluntary hospital expense insurance. . . .

"While voluntary surgical expense and medical expense insurance plans, newer types of protection, cover approximately 26,000,000 and 9,000,000 respectively, at the same time, more than 31,000,000 persons, over half the employed civilians in the country, have benefits for loss of income due to disability . . ."—*The Life Insurance Association of America.*

* * *

"Dear Mr. Ewing:

". . . Regardless of your beliefs, America enjoys the best health of any nation in the world. This can be proven by figures.

"You speak of 325,000 preventable deaths every year in the United States. This figure is broken down to 120,000 who die needlessly of communicable diseases. If the spread of communicable disease is not being controlled properly, whose responsibility is that? The blame must rest with the Government which controls public health.

"Cancer and heart disease, you state, take 115,000 persons per year needlessly . . . is socialized medicine going to prevent these deaths?

"You also state that 40,000 deaths which are due to accidents are preventable. Can socialized medicine prevent these deaths' . . ."—*Gilson Colby Engel, M. D., president, Medical Society of the State of Pennsylvania, regarding the Ewing Report.*

* * *

". . . The catch in socialized medicine is, of course, that the insured can always take out more than he pays in. Unfortunately, the decline of medical standards, which always accompanies the encroachments of bureaucrats into professional matters, means that the medical care which can be guaranteed becomes less and less worth getting."—*Saturday Evening Post.*

* * *

"Whereas, great pressure is being exerted on Congress to pass legislation which would place under government control the health and medical care of the people of the United States, and

"Whereas, such action would impair or destroy the personal interest, initiative, and private research on the part of the medical profession under the control of a paternalistic bureaucracy with direct socialization as a result, therefore be it

"Resolved, that the twenty-third Women's Patriotic Conference on National Defense express its emphatic opposition to the establishment of socialized medicine and thereby the expansion of bureaucracy in the United States . . ."—*Resolution adopted.*

* * *

"Our system of private medicine is not perfect. There are some chiselers and incompetents among physicians as there are among farmers, workers, businessmen and politicians . . . but by and large our system has worked well. Most doctors are honest and capable . . . Physician groups have recognized imperfections in our system and have tried to eliminate them. The general abandonment of rebates on spectacles furnishes a recent example.

"But to scrap the successes of private medicine and substitute the costly failures of compulsory systems would be folly. It would make us unhealthy, unwealthy, and very, very, unwise." *Chicago Journal of Commerce.*

Better Health Services For Ohio . . .

Inter-Organization Committee Reveals Deficiencies in Financing of Ohio Department of Health; Suggests How Services Can Be Improved

THE Ohio Committee on Public Health, in its recently completed report, recommended that the 98th General Assembly of Ohio appropriate sufficient funds to enable the Ohio Department of Health to carry on its present services without dependence on the Federal government; that the General Assembly appropriate sufficient funds to meet the state subsidy promised under provisions of the General Code to local health departments which meet certain requirements; and that Federal grant-in-aid funds to the State (now constituting 71 per cent of the State Department's budget) be largely channeled through to local health units.

The Committee, after a thorough study of over-all public health in the State as well as the Ohio Department of Health, formulated its findings under 10 conclusions, out of which are developed its final recommendations.

THE COMMITTEE

The Ohio Committee on Public Health had its beginning early in 1948 as the result of a need expressed within several organizations for more efficient and extensive public health services.

A committee consisting of representatives of five organizations—four organizations interested primarily in rural health and the Ohio State Medical Association—was named in January, 1948, to study the problem of financing the Ohio Department of Health.

After preliminary discussion, the committee decided, first, that its purposes should be expanded to include a study of the existing public health set-up throughout the State, with special consideration being given to organization, financing and recodification and possible revision of various statutes; and secondly, that since such an undertaking was not entirely a matter of rural areas, the committee should be expanded to include other organizations interested in public health.

The result of this recommendation was the expansion of the Committee to include the following organizations, representatives of which concurred in the final report: The Ohio State Grange, the Ohio State Medical Association, the Ohio State Association of Township Trustees and Clerks, the Ohio Farm Bureau Federation, the Ohio Federation of Labor, the Congress of Industrial Organization, the Ohio Congress of Parents and Teachers, the Ohio State Nurses Association, the Ohio Hospital Association, the Ohio Tuberculosis and Health Association, Ohio State Veterinary Medical Association, and Ohio State Federation of Women's Clubs.

Mr. Charles S. Nelson, executive secretary of the Ohio State Medical Association, was elected chairman and Mrs. Litta K. Roberson of the Ohio Farm Bureau Federation was elected secretary. Miss Mildred Rankin was engaged to carry out the study under direction of the Committee. Expenses involved were financed by contributions from component organizations.

OBJECTIVES

At one of its early meetings the Committee adopted the following objectives:

1. To study ways and means of providing more efficient public health services for the citizens of Ohio.
2. To make recommendations for the improvement of public health organization and financing in Ohio on a state and local level with a view to insuring a strong state health department and to facilitate the establishment and operation of efficient local health units with good programs.
3. To carry on an educational program for the purposes of informing the citizens of Ohio and public officials, including members of the General Assembly, of the essential services and the cost of these services for the protection of the health of all the people.

CONCLUSIONS

Following are the ten basic conclusions announced by the committee with suggested means of correcting deficiencies:

1. The Ohio Department of Health is performing little more than the elementary services required of an up-to-date health department.

This is not the fault of the present administration, the Committee points out; it is due to a situation beyond its control. Meager appropriations by the State have compelled the department to confine its activities to minimal services.

2. Additional and expanded services must be provided by the Ohio Department of Health if the people of Ohio are to have the health protection and services which modern public health practice affords.

Under existing conditions the department cannot discharge all the responsibilities placed on it by the Ohio public health laws and it cannot meet the increasing health problems and needs of the people of Ohio, the report states. More trained, experienced and aggressive personnel is needed. Additional advisory and auxiliary serv-

ices for local health departments should be developed by the Ohio Department of Health. Present budget restrictions prevent the development of such services.

3. Some of the additional services which the department should provide for local health units and for the state as a whole are as follows:

(a) Consultation service to industrial nurses.

(b) Increased facilities at the Ohio Department of Health Laboratory to provide more diagnostic services for local public health departments, especially laboratory services covering some of the infectious diseases now recognized as public health problems.

(c) Intensified stream pollution engineering services.

(d) District offices for direct consultation services for local public health departments in the fields of generalized public health nursing, nutrition, health education, environmental sanitation and epidemiological problems.

(e) Additional nursing consultation in specialized fields, for instance in vision and hearing testing programs in the schools and elsewhere.

(f) More consultation service in nutrition, for instance as it relates to the school lunch programs and supervision of food in public hospitals, county homes, correctional institutions, etc.

(g) Meat inspection consultation services with particular reference to diseases transmissable from animal to man, for instance, brucellosis and trichinosis.

(h) Administrative practice consultation services to local health departments to provide more efficient record-keeping, reporting and business management within local health units.

(i) More health education consultation services to local health departments to assist them in doing a better job of health instruction among the people of their community.

(j) Educational and consultation services relating to programs for the control of cancer, diabetes, heart disease and tuberculosis.

4. Present methods of financing the minimal basic services now being performed by the Ohio Department of Health are neither sound nor practical.

The record shows that **only 29 per cent** of the money expended by the department in 1948 for departmental activities was **provided by the State of Ohio. The remaining 71 per cent came from the Federal government.** Reducing this to dollars and cents; of the $1,246,169 spent by the department in 1948, $885,560.73 consisted of grants-in-aid from the Federal government and $360,608.94 from the State treasury.

Fifty-eight per cent of the money sent to Ohio by the Federal government ($1,525,137) primarily for improvement and expansion of the work of local health units had to be used to keep the Ohio Department of Health functioning. Of 276 persons employed by the Ohio Department of Health to carry on activities **required by Ohio public health laws,** 170 were paid out of Federal grants-in-aid.

The situation boils down to this: If the flow of Federal money should be curtailed, or stopped, or should the Ohio Department of Health send to local health units their fair share of Federal allotments to Ohio, the department would be forced to drastically reduce the number of its employees, curtail the work of most of its divisions, and abandon altogether some of its essential services.

5. Dependence by the State of Ohio upon Federal grants-in-aid for financing the essential functions of the Ohio Department of Health, an integral part of the state government, is unsound, unwarranted in the case of a wealthy state like Ohio, and should not be allowed to continue.

Ohio has a notoriously bad record when it comes to financing its own Department of Health, the report states. An analysis of the appropriations made by the 48 states in 1948 shows that **Ohio ranked next to last with a state appropriation of 9.9 cents per capita** for public health exclusive of hospital care. **The average appropriation of the 48 states for such purposes was 50.4 cents per capita.** Thus Ohio which ranks **fifteenth in per capita income,** ranks **forty-seventh in per capita appropriations for public health.**

6. That Ohio has not complied with the intent of Congress with regard to the use of Federal grants-in-aid for public health activities is evidenced by the record.

The intent of Congress when it enacted the Social Security Law and other grants-in-aid statutes was twofold: First, that Federal funds should be used as **supplements to expenditures by the states themselves**—not to become substitutes for money which the states are expected to provide for primary public health activities; secondly, that the major portion of the Federal funds alloted should be **channeled by the states to local public health units,** especially to units in need of financial assistance and having greater public health problems.

7. Public health activities in Ohio would be seriously jeopardized should the Federal government insist on compliance with the intent of Congress in enacting the grants-in-aid statutes.

Recent statements by officials of Federal agencies indicate that they may in the near future require each state to assume a greater financial responsibility for essential public health services as a prerequisite for receiving Federal grant-in-aid funds.

8. Curtailment of the activities of the Ohio Department of Health would be a serious blow to work of all local health departments.

Local units must be able to call upon the

Ohio Department of Health for expert consultation and technical services. They must look to the central agency for laboratory services, mobile X-ray units in tuberculosis case finding, mobile dental units, and other specialized technical services which cannot be provided efficiently and economically by many local health districts.

9. The major portion of Federal grant-in-aid money should be allocated to local health units.

The most effective public health programs are those which provide direct services to the people and tackle grass-roots problems. Requests received by the Ohio Department of Health from local health units for additional Federal grants give ample evidence of the need of many local units for financial assistance in readjusting their programs to meet local needs and problems.

10. The State of Ohio is not meeting its financial obligation to local health departments as provided by Ohio statutes.

Ohio statutes provide that the State should make a financial contribution in the amount of $2,000 annually to each local health department which can show that it spends at least $4,000 a year for the combined salaries of a health commissioner, public health nurse and a clerk (Section 1261-39 G. C.). This law was enacted in 1919. In only three years since that time has the State Legislature appropriated sufficient funds to meet this state subsidy in full. In 1948 the prorated allocation to health districts under the subsidy was only 86 per cent of the maximum provided by statute.

RECOMMENDATIONS

The Ohio Committee on Public Health concluded its report with the following recommendations for meeting the problems and deficiencies in the Ohio Department of Health:

"The Ohio Committee on Public Health recommends that the 98th General Assembly of Ohio appropriate sufficient funds to enable the Ohio Department of Health to carry on present activities and such additional activities as the Department is required to assume without depending on Federal grant-in-aid funds to pay for essential state services.

"In considering the biennial appropriation for the Department of Health for 1949-50, the General Assembly should note that the total operating cost of the Department of Health in 1948 was $1,246,169.67. Inasmuch as that amount was required to enable the Department to carry on activities which are accepted as highly essential to the public health program of the entire state, the Committee recommends that the General Assembly should appropriate from state funds at least that amount of money annually for the biennium, 1949-50.

"The Committee further recommends that the 98th General Assembly of Ohio appropriate sufficient funds to discharge in full the obligation to local health units as provided in Section 1261-39 of the General Code. The amount needed is approximately $360,000 per year."

ROUNDUP ON PREPAID MEDICAL CARE PLANS

Over 205,000 persons were added to Blue Shield and Blue Cross membership recently through the nation-wide enrollment of employees of the Ford Motor Company. Approximately 200,000 of these subscribers were enrolled in Michigan where the bulk of Ford operations are located.

With addition of Ford subscribers, total enrollment in the non-profit medical care plans went well beyond the goal of ten million set for the end of 1948 in previous estimates.

* * *

Blue Shield Plans will convene at the Hollywood Beach Hotel in Hollywood, Fla., on April 18-21, for their 1949 Annual Conference. Among the important items on the agenda for the 1949 meeting will be proposed new membership standards for Blue Shield Plans affiliated with Associated Medical Care Plans, development of effective programs by local plans for improved relations between physicians and plans, accelerated enrollment campaigns, underwriting problems involved in selling individuals and rural communities, and cooperation with the American Medical Association in its national public education campaign.

* * *

Recognition of the ten millionth subscriber, to be announced by Blue Shield in Florida, will be observed with appropriate ceremonies at the 1949 Annual Conference of Blue Shield Plans in Hollywood, Florida, during April.

* * *

Ohio Medical Indemnity, Inc., (the Ohio Doctors' Plan) as of January 31, had contracts covering 473,019 persons, an increase of more than 7,750 additional persons covered during the month of January.

* * *

In accepting membership applications from five additional prepayment plans at its meeting on January 15-16, the Blue Shield Commission announced that membership in A. M. C. P. had reached a total of sixty plans.

Admitted to full membership in January were: Arkansas Medical and Hospital Services, Little Rock; Central New York Medical Plan, Syracuse; Klamath Medical Service Bureau, Klamath Falls, Oregon; Physicians Association of Clackamas County, Oregon City, Oregon (re-instatement); and Puerto Rico Hospital Service Association, San Juan, Puerto Rico.

Rural Health Activities . . .

A. M. A. Committee Outlines Eleven-Point Program for Medical Profession at Chicago Meeting; Ohio Well Represented at National Conference

A comprehensive program to bring a high standard of health and medical care to rural communities was adopted by the American Medical Association Committee on Rural Health and announced during the fourth annual National Conference on Rural Health, sponsored by the A. M. A., February 4 and 5, in Chicago.

The program envisions coordination and utilization of successful efforts now in operation by the medical profession, lay groups, agricultural extension organizations, and government to insure better rural health. The plan calls for active and positive steps through the following media:

1. State and public health services for general community hygiene and communicable disease control; public health nursing; and well-baby conferences and clinics.

2. The Hill-Burton Hospital Construction Act operating where the people of a community demonstrate sufficient desire for such facilities.

3. Medical scholarships provided by medical associations, farm bureaus, and through legislative appropriations to be given to deserving boys and girls, without discrimination, for medical and nursing education, where they agree to practice for a time in rural areas.

4. Agricultural school extension services where they utilize their home demonstration courses; 4-H clubs; health specialists whose special duty it is to organize health councils; and the teaching of better farm methods.

5. Parent-Teacher Associations where they encourage examination of school children for hearing, sight, heart, hernia, immunization, school hygiene, as well as physical education.

6. Special health groups such as tuberculosis, polio, cancer, heart, which do considerable educating within narrow limits.

7. The application of voluntary prepaid medical and hospital care plans to rural communities, taking into consideration that several of the large farm groups have their own indemnity prepaid medical and hospital plans.

8. A promotion of state and county health councils, the medical profession acting cooperatively with organized farm groups and other civic, church, and school organizations and special health groups for the purpose of health education and health activities of local character.

9. A plan to bring the medically indigent, or low income farmer into voluntary prepaid medical plans, which may involve some state financial aid.

10. Use of the health education programs of farm groups.

11. Encouragement of the civilian population, as distinguished from governmental official action, to help itself.

Dr. Carll S. Mundy, Toledo, is vice-chairman of the A. M. A. Committee and is chairman of the Rural Health Committee of the Ohio State Medical Association.

At a meeting of the National and State Committees on Rural Health of the A. M. A., held at American Medical Association Headquarters February 3, the day previous to the National Conference on Rural Health, Dr. Donald G. Anderson, secretary of the Council on Medical Education and Hospitals, said that medical schools are cooperating in the solution of the rural health problems. He declared that a number of schools now present the problem of the rural areas, needs, advantages, attractions, using outstanding rural physicians as lecturers in the classroom. Some schools have revised the curriculum to give material to students who have rural general practice in mind. This includes formal lectures on medical problems the rural man must face, and preceptorships under rural physicians.

The speaker said that some medical schools are also: providing the rural practitioner with clinical and laboratory consultation services where needed; mailing him requested medical books from the school library; and cooperating with scholarship programs for rural students in medicine.

Dr. J. Martin Byers, Greenfield, officially representing the Ohio State Medical Association Committee on Rural Health, outlined a nine-point syllabus of lectures on rural practice, which will be considered by the Ohio State Medical Association for presentation to the Ohio medical schools.

The following two days, the committeemen met with the farm groups. In discussing the health programs of national farm organizations, Mrs. J. Laning Taylor, educational director of the National Cooperative Milk Producers Federation, said that her organization is emphasizing quality and sanitation in milk production, eradication of bovine disease, soil building, school lunch

programs, and the support of voluntary prepayment medical and hospital care programs.

Joseph W. Fichter, Columbus, Ohio, chairman of the Interim Committee on Health of the National Grange, announced that current health programs of the Grange included the problems of cancer, tuberculosis, heart diseases, mental health, and nutrition. Mr. Fichter stated that a rural organization committee of which he is a member, has held the first of a series of meetings with representatives of the Association of Medical Colleges, and with the secretary of the A. M. A. Council on Medical Education and Hospitals to discuss the problem of more physicians for rural areas.

A representative from the Farmers' Union stated that her organization is for the Compulsory Health Insurance program and a few moments later said that the Farmers' Union believed in free choice, local control and the preservation of voluntary health insurance plans.

Mr. H. E. Slusher, chairman of the Medical Care Committee of the American Farm Bureau Federation, told of the resolution favoring voluntary prepayment plans, adopted at the annual meeting of his organization in December; and outlined the Farm Bureau's constructive program for the improvement of rural health, involving the fundamentals of education and legislation. Mr. Slusher stated that compulsory health insurance has not solved, but aggravated the health problems in England and Austria, and that there can be no such thing as health improvement under these plans, and it is wrong to tell the people that there would be.

Dr. Jonathan Forman, editor of *The Ohio State Medical Journal,* served as co-chairman of the Section on Nutrition and the Soil for the conference. Other sections include Cooperative Health Programs for Rural Areas; Environmental Hazards; and Health Education.

Attending the conference from Ohio were: Dr. Mundy; Dr. Byers; Dr. Forman; Dr. E. G. Caskey, Mineral Ridge, member of the Ohio State Medical Association's Committee on Rural Health; Dr. E. A. Ockuly, president-elect, and Robert Elwell, executive secretary, of the Academy of Medicine of Toledo and Lucas County; and Hart F. Page, secretary to the Ohio State Medical Association Committee on Rural Health.

Course on Diabetes

The Frank E. Bunts Educational Institute and Cleveland Clinic will present a continuation course for physicians entirely devoted to the diagnosis and management of diabetes and its complications, March 17-19. Information may be obtained by writing the director of education of the institute, 2020 E. 93rd St., Cleveland 6.

Veterans Administration

Re-evaluation of the Veterans Administration Hospital expansion program in the light of experience gained in the three years since the end of the war has indicated a need for changes in the program, Carl R. Gray, Jr., Administrator of Veterans Affairs, announced.

Study has shown that estimated needs for hospital beds made during and immediately after the war were considerably larger than actually has proven necessary, although admission policies have been such that more than two out of three patients are admitted for non-service-connected ailments.

On the strength of developments and based on careful restudy of 64 individual projects not yet under contract, the President has ordered a reduction of 16,000 beds, including temporary and emergency beds. To effect this, V. A. plans the cancellation of 24 new hospitals and reduction in the size of 14 others.

None of the hospitals is beyond the planning stage. V. A. currently has 31 new hospitals in various stages of construction.

Projects to be altered in size from present plans include three in Ohio. The Cincinnati general medical project has been reduced from the planned 750 beds to 500; the Cleveland general medical project from 1,000 to 500; and the Cleveland neuropsychiatric from 1,250 to 1,000. These are among 14 such projects throughout the country being reduced in size. Twenty-four other projects are scheduled to be eliminated under terms of the President's order.

* * *

The first specially designed home for a paralyzed veteran—built with the help of a grant provided under Public Law 702 by Veterans Administration—is under construction in Richmond, Va. The home will have a number of features planned for comfortable wheel-chair living.

* * *

Privately owned pharmacies and those operated by Veterans Administration filled a total of some 4,000,000 prescriptions for veteran-patients during 1948, E. Burns Geiger, chief of V. A.'s pharmacy division, estimated.

About half a million of the prescriptions were filled by 25,000 privately operated pharmacies throughout the country, taking part in the V. A. home-town pharmacy program. The remaining 3,500,000 prescriptions were filled by 333 pharmacists in V. A. hospitals, homes and regional offices.

* * *

By December 1, 1948, Veterans Administration had approved 237 applications of paraplegic veterans for Federal aid to acquire homes specially designed for wheel chair living.

Medical-Health Bills in Legislature . . .

Dozens of Measures of Vital Interest to Medical Profession Pending; Action "Back Home" Necessary To Keep Legislators Properly Informed

DOZENS of bills with health and medical angles, some of them of vital interest to the medical profession, are among the 196 Senate Bills and 653 House Bills which were pending before committees of the 98th Ohio General Assembly as this issue of *The Journal* went to press.

A number of the measures in the hopper will have to be opposed vigorously by the medical profession. Others will be supported and their passage urged. The Columbus Office staff and members of the Legislative Committee are watching all proposals carefully and weekly reports are being furnished to the Legislative Chairmen and officers of all County Medical Societies for their information and information of all members.

Aggressive action "back home" will be necessary to keep members of the General Assembly properly informed on the views and policies of the Ohio State Medical Association on the various bills. Weekly interviews with candidates will be essential.

SOME IMPORTANT MEASURES

Following are some of the measures of special interest, with comments on their status and the atttiude of the State Association on them. Some of the bills have not been studied as yet by The Council. Policies on these will be announced as soon as they have been analyzed:

H. B. 95—To provide for the administration of the new Ohio Tuberculosis Hospital at Ohio State University Medical Center by the Ohio Department of Health, passed by House, on Feb. 17. Has support of O. S. M. A.

H. B. 99—To establish a registry and examinations of public health sanitarians in the Ohio Department of Health, passed by House on Feb. 17. Has support of O. S. M. A.

H. J. R. 24—To memorialize Congress not to enact legislation to socialize medicine.

H. B. 293—That old-timer, the Christian Science Bill—to write an exemption into the Medical Practice Act so C. S. practitioners can practice openly and charge a fee without proving qualifications, taking an examination, or securing a license to engage in what is, in effect, the practice of healing (practice of medicine), has been referred to the Judiciary Committee. It must be opposed.

H. B. 304—To establish a separate examining and licensing board for chiropractors. It is like those of past years, which grant many additional rights to chiropractors, give them complete control of the examination and of licensing, and upset the present unified system which has worked well and been a safeguard to public health. **This bill will have to be opposed vigorously.**

BARBITURATE CONTROL BILL

H. B. 308—This proposal to establish rigid controls of the sale and distribution of barbiturates is being sponsored jointly by the Ohio State Medical Association and the Ohio State Pharmaceutical Association. It is a constructive measure, providing that barbiturates cannot be sold by druggists except on the prescription of a licensed physician and that when they are dispensed by a physician he must keep a record of the name and address of the person receiving the drug **if the amount dispensed to any one patient for use within a 48-hour period exceeds 12 grains.** This would not affect routine dispensing by physicians in emergency or mild illnesses. Records of purchases would have to be kept by druggists and physicians to assist inspectors of the State Board of Pharmacy, which will administer and enforce the law. Stringent penalties for violations are provided. The situation with regard to barbiturates is becoming more serious daily in Ohio. There have been many accidental deaths and suicides and crimes committed by those using the drug. The public is demanding control measures. Several cities have city ordinances under consideration. House Bill 308 is similar to laws in other states which have not worked a hardship on druggists and physicians but have been beneficial to the public. It would be wise for the medical profession to get behind this bill, not only because of its worthy purposes, but also because it sets up sound and reasonable procedures—which might not be the case if we let others attempt to meet the problem.

SPONSORED BY O. S. M. A. ALSO

S. B. 126—To provide that any person holding a license to practice medicine, osteopathy or any limited branch of medicine **must show the degree he holds** (M. D., D. O., D. C., etc.) on signs, letterheads, etc. This bill is sponsored by the Ohio State Medical Association by order of the House of Delegates which adopted a resolution at the 1948 Annual Meeting, Cincinnati. It is aimed to eliminate confusion in the mind of the public where the practitioner merely uses the word "Doctor" or "Dr." before his name.

S. B. 133 and H. B. 613—To establish naturo-

pathic examining and licensing boards were introduced. **These two bills will have to be opposed vigorously.** It would permit these alleged healers to do about everything and set up a special board outside the present single examining and licensing system under the Medical Practice Act.

H. B. 75—To provide for the vitamin enrichment of flour and bread was given its first hearing, Feb. 16, by the House Health Committee. This has been approved by the O. S. M. A.

S. B. 95—To provide for the examining and licensing of practical nurses will be heard soon by the Senate Health Committee. A similar bill, H. B. 462, was introduced in the House. **The policy of the O. S. M. A. on these proposals will be decided by the Council in the near future.**

PRIVILEGED COMMUNICATIONS

S. B. 151—Would do away with much of the present law relating to privileged communications between physician and patient in litigation where the physical condition of a party is an issue. It is sponsored by the Ohio State Bar Association. **The Council will adopt a policy on this measure at an early date.**

S. B. 106—Amends the laws relating to disposition of dogs. This is being checked carefully as to whether it would interfere with the use of dogs in medical research.

H. B. 44—To transfer the sanitary inspection of restaurants from the State Fire Marshal to the Ohio Department of Health was given its first hearing by the House Health Committee. **The O. S. M. A. approves of this legislation in principle.**

S. B. 188—To permit Division of Aid for Aged to make lump-sum payments to out-patient departments of hospitals for care to pensioners, amount to be outside $200 limitations. Referred to Finance Committee.

MISCELLANEOUS PROPOSALS

H. B. 564—To establish a commission to recodify the public health laws of Ohio.

H. B. 553—To increase compensation of coroners in certain counties.

H. B. 550—Re: disposal of sewage and waste in Ohio River.

H. B. 514—Administration of poor relief shall be by county commissioners.

H. B. 493—To permit sending of patients to mental hygiene institutions for observation for period of six months.

H. B. 502—To make appropriation to Ohio State University for cancer research.

H. B. 449—To increase from 50 per cent to 75 per cent the proportion of state aid to counties and cities for poor relief.

H. B. 370 and S. B. 134—To establish a commission to study compulsory disability insurance as a part of unemployment insurance.

H. B. 447—To provide year-round hospital care for those on relief; to increase state aid to detention hospitals of mental hygiene institutions.

H. B. 446—To establish commission to study problem of chronic alcoholism and to provide program for care and treatment of alcoholics.

H. B. 445—To create commission to study state aid to hospitals.

H. B. 430—To establish a state insurance fund to compensate those injured and dependents of those killed as a result of motor vehicle accidents.

H. B. 386—To create a commission to provide a juvenile psychiatric clinic near the Lima State Hospital.

S. B. 196—Removes ceiling of $6.00 per day for hospitalization of indigents injured in automobile accidents.

H. B. 220—To provide that relief granted to indigents by the county shall not include hospital care as defined in Section 3391 of the General State Relief Act.

H. B. 223—To authorize county commissioners to provide medical, dental, optometrical and hospital care to the needy blind.

H. B. 233—To exempt physicians, dentists and public health nurses employed by the state and public subdivisions from compulsory retirement at age 70. (Similar to S. B. 73 and H. B. 45.)

H. B. 170—To increase weekly benefits under Workmen's Compensation for partial or temporary disability to $35.00.

H. B. 193—To authorize the State to reimburse counties 50 per cent of costs of providing care for dependent children.

H. B. 21—Court may order physical examination of litigant when physical condition is an issue, referred to House Judiciary Committee.

S. B. 23—Requiring registration of marriages, divorces and annulments with State Department of Health.

S. B. 26—Increasing costs of certified copy of birth certificate from 25 to 50 cents, first hearing by Senate Health Committee on Wednesday of this week.

COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, April 19-22.

American Academy of General Practice Annual Scientific Assembly, Cincinnati, March 7-9.

American College of Physicians, Annual Session, New York City, March 28-April 1.

Annual Conference of County Society Presidents, Secretaries and Committeemen, Columbus, March 20.

Bowel Management of the Irritable Colon . . .

"As an aid in reestablishing a normal rhythm, the temporary use of a bland bulk-producer . . . may be beneficial. . . . Patients having irritable colon who believe they are suffering from constipation commonly use high-residue diets, . . . They may not realize that this practice is similar to using irritating cathartics or large enemas and often increases the tendency to constipation by increasing spasm of the colon."*



Metamucil is "a bland bulk-producer" which gently initiates reflex peristalsis and movement of the intestinal contents. The "smoothage" therapy of Metamucil encourages a return of the normal function of the colon without irritating the mucosa.

METAMUCIL®

is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Collins, E. N.: The Diagnosis and Treatment of Irritable Calon: Physiologic, Local, Irritative and Psychosomatic Factors, M. Clin. North America 32:398 (March) 1948.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

PAYMENT OF A. M. A. ASSESSMENT ONLY PART OF THE ANSWER

Foolish will be the physician who thinks that, having paid his $25.00 A. M. A. assessment, he can now sit back, relax and expect to see rabbits pulled out of hats. The public education fund of the A. M. A. will be used to turn out the material and the technics for enlightening the public. However, this ammunition will have to be fired by members of the medical profession.

In other words, a large part of the responsibility for getting the proper information to the people rests on the shoulders of the individual physician. Experts can do the planning and turn out the information but the real action will have to be supplied by every last physician who believes that it is time for the medical profession to tell the people about steps which have been taken, and can be taken, to meet their health problems without resorting to radical measures such as those which have been presented to the present Congress.

No, mere payment of the $25.00 assessment is not the answer. It is only a step in developing the means to an end. The individual physician, working with other citizens who believe there are better methods than compulsory sickness insurance, is still the keystone of any and all public education programs undertaken.

FARM BUREAU ASKS CONGRESS TO GO SLOW ON S. 5

According to the *Washington Report on the Medical Sciences*, the American Farm Bureau Federation has dispatched an urgent appeal to the U. S. Senate Labor and Welfare Committee to defer action on S. 5, the compulsory sickness insurance measure.

The following excerpts from the telegram urging no action now are of unusual interest and importance, considering the size and potency of the membership of the Farm Bureau:

"Tremendous progress has already been made in meeting our health problems through voluntary health associations. . . . We strongly oppose plans under which the Federal government would embark on programs providing similar services on a compulsory basis. . . . We have consistently opposed compulsory health insurance . . . because we believe the desired result can be achieved more completely and more desirably by other means. . . . We favor . . . voluntary programs providing hospital and medical care, facilities to train more doctors and nurses, establishment of local public health units and a broad program of health education . . . (these would) result in better medical service in greater volume than will be provided by any compulsory program and at the same time will do much to develop individual self-reliance and independence."

This message would seem to refute the feelings of some who were ready to write off the farm population after last November's election. The farmer knows, if he thinks at all, that he can't have full security and great freedom at the same time, as pointed out recently by the *Ohio Farmer*.

At the same time, the farmer has awakened to the health problems and health needs of his family and community. He wants them solved and he is entitled to that. Solutions can be found for most, if not all, of the rural health problems without reporting to the so-called "welfare state." Much can be done through close cooperation between farm folks, health authorities and the medical profession. That has been proven by experiences here in Ohio. Such programs should be continued and expanded.

SUGGESTIONS FROM PEOPLE SOLICITED

The Public Relations Committee of the Tuscarawas County Medical Society has announced through the press that the society wants persons who are dissatisfied with the services they are receiving from physicians of that county to send in complaints and constructive criticism regarding the correction of flaws in the medical services of that area.

This is public relations in action. It should be an example for all county medical societies. By sitting down with persons who have real or imaginary grievances and discussing with them their problems, the medical profession can go far toward eliminating many, many of the situations which are provoking the public and causing trouble for physicians. It will take courage and patience on the part of the medical profession to do this job but it is something worth doing.

TIME FOR N. P. C. TO BOW OUT OF THE PICTURE

Now that the American Medical Association has initiated plans to carry on a public education program which, if present indications are accurate, will be dignified and constructive but at the same time effective, it is high time for the National Physicians Committee to bow itself out of the picture, in our opinion. It would do well to follow the example set by the United Public Health League, which has announced

Clinically approved

Today, there is a wealth of clinical evidence supporting the use of Meonine as a supplement to the protein-rich diet usually prescribed for liver damage associated with malnutrition, pregnancy, allergy, certain chemical poisons, and alcoholism.

Typical of this evidence is a Beams-Endicott paper*. The authors reported that a methionine supplement seemed to cause regeneration of the liver parenchyma, in cirrhotic patients, irrespective of the amount of protein and vitamins in the diet.

Complete bibliography on request. Meonine is supplied in 0.5 gram tablets. Wyeth, Philadelphia, Pa.

*Beams, A. J., and Endicott, E. T., Histologic changes in the livers of patients with cirrhosis treated with methionine, Gastroenterology 9:718-735 (Dec.) 1947.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

MEONINE®

for liver damage

(dl-Methionine Wyeth)

Wyeth®

that it is closing its Washington Office now that the A. M. A office there is functioning efficiently and effectively.

Continued activity by the N. P. C. will create additional confusion in the minds of physicians and the public. It will retard speedy development of the A. M. A. program.

The A. M. A. has decided to do the job. It can and will, in our opinion. United backing of one single agency to head-up this activity is what is needed. The A. M. A. is that agency. There is no need for duplicating, overlapping organizations. In fact, a continuation of this situation will result in disunity, waste, and inefficiency.

GIVE THE SUMMER ROUND-UPS YOUR ACTIVE ASSISTANCE

Plans for the 1949 Summer Round-Up of preschool children are now being made by the Summer Round-Up Committee of the Ohio Congress of Parents and Teachers, under the direction of Mrs. Florence Martin, Toledo. Local Parents and Teachers units will soon be making local arrangements for these projects.

The Ohio State Medical Association has endorsed the Summer Round-Up year after year, urging county medical societies and physicians individually to cooperate. The Ohio Congress of Parents and Teachers has deeply appreciated this assistance which has been instrumental in providing the local groups in most areas with adequate and competent professional services.

In our opinion, the state and local Parents and Teachers groups should have the advice and assistance of the medical profession in making the Summer Round-Ups a complete success. They have paid many dividends in the past and are an important phase of a good community health program.

This would be a splendid activity for the School Health Committee of the County Medical Society. Through such a committee, the local Parents and Teachers groups can obtain the counsel which they solicit and should have. It would be a real demonstration of good community relations on the part of the medical society. Through such a set-up, all physicians in the community could be brought into the program. This would make it unnecessary for a few to do all the work and shoulder all the responsibilities. It certainly would be concrete evidence that the medical profession as a whole and individually is interested in the over-all health of the community. There can be no argument over the benefits which will accrue to the children involved.

Here's hoping the Summer Round-Up in every community receives the backing and active support of the local medical society and large numbers of physicians.

NOTHING NEW ABOUT IT AS THE RECORD SHOWS

Varying reactions among physicians have been registered since the American Medical Association at its St. Louis meeting several months ago decided to step up its public relations, public education and legislative programs. Some have said: "It's action long overdue; should have been done long ago." Others have disagreed, contending: "The medical profession should keep its hands out of legislative matters; let the public take full responsibility." Some have cried: "It's a lobby!" Others have pointed out: "Good! We have to meet fire with fire." So it goes.

Peculiarly enough few physicians realize that the American Medical Association and its component state and local societies have been doing all of these things for lo, these many years—and not too badly, as some would want one to believe.

To those who doubt this observation, we quote the following excerpt from the *Columbus Medical Journal* of July, 1899—fifty years ago—as taken from the *Cleveland Medical Gazette*, referring to action taken at the Fiftieth Annual Session of the American Medical Association held in Columbus:

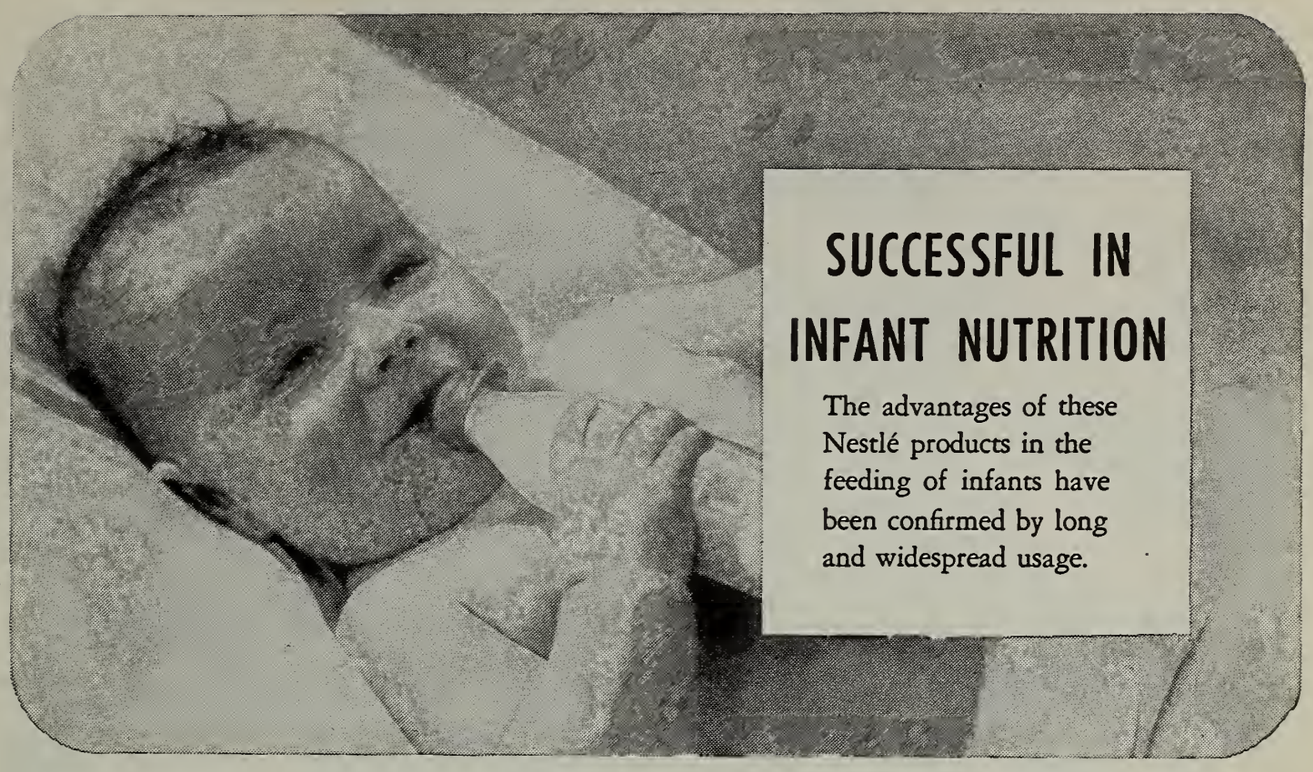
". . . The State Society of Ohio this year carried its point in securing a national committee on legislation, consisting of three members of the A. M. A. in and about Washington, and an auxiliary committee of one from each of the several state societies of legally qualified practitioners of medicine. The overture of the Ohio Society was referred, as at Denver, to the executive board, but the executive board did not, as at Denver, table the motion, but reported it to the board of trustees with a recommendation for approval. The board of trustees recommended the plan to the Association for its adoption, and made an appropriation to carry out its provisions, and on the recommendation of the board of trustees, the motion was carried in the Association, so that the profession of Medicine in the United States of America has now an organization by which its influence can be brought to bear upon legislation in Washington in all questions relating to sanitary and medical matters."

OCCASIONAL SUGGESTION TO OFFICE GIRL MAY PAY DIVIDENDS

Recently each member of the Association was mailed a copy of "Date With the Doctor," a pamphlet of hints on how the physician's receptionist can help him in his daily contacts.

There is more meat in this booklet than can be digested with a mere scanning of its pages. An occasional suggestion from the doctor on points covered, or an occasional question on its contents, might help to keep it handy for ready reference.

The receptionist who applies most of the suggestions offered in this pamphlet will be an invaluable asset.



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New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since December 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ASHTABULA COUNTY
Harold C. Franley, Jefferson
Clarence B. Johnson, Ashtabula
Eugene N. Wright, Ashtabula

ATHENS COUNTY
Richard H. Schaefers, Nelsonville

BUTLER COUNTY
Robert C. Cogswell, Jr., Hamilton
Louis N. Gould, Hamilton

CARROLL COUNTY
Thomas J. Atchison, Carrollton

CLARK COUNTY
George L. Clauer, Springfield
Martin J. Cook, Springfield
Carl S. Jenkins, Springfield
William E. Leeper, Jr., Springfield
Paul W. Schanher, Jr., Springfield

CLERMONT COUNTY
George T. Pack, Milford

COLUMBIANA COUNTY
Harry C. Cope, East Liverpool
M. C. Hanysh, Lisbon
Harold F. Hoprich, Salem
Gladys T. McGarey, Wellsville
Burruss B. McGuire, Lisbon
Milton Wolpert, East Liverpool

CUYAHOGA COUNTY
Ilka W. Adler, Chagrin Falls
Donald F. Bauman, Cleveland
James F. Berwald, Cleveland
James B. Daley, Cleveland
W. F. Gibbons, Cleveland
Gorden W. Hasse, Cleveland
Ralph J. Honzik, Cleveland
Howard H. Hopwood, Jr., Cleveland
Huldrick Kammer, Cleveland
Nelson E. Klamm, Cleveland
Simon Koletsky, Cleveland
Edward S. Kozikowski, Cleveland
Robert B. Love, Cleveland
Charles W. Marsh, Jr., Cleveland
Hugh A. O'Neill, Cleveland
James W. Reagan, Cleveland
L. James Regan, Cleveland
George H. Reinhardt, Cleveland
Arthur F. Ritchey, Cleveland
Salvatore M. Sancetta, Cleveland
Frederick W. Sunderman, Cleveland
Richard L. Taylor, Cleveland
Jacob G. Warden, Cleveland

DARKE COUNTY
John F. Houser, Versailles

DEFIANCE COUNTY
Joseph E. Horton, Defiance

DELAWARE COUNTY
Mary E. Kinsey, Ashley

FAIRFIELD COUNTY
William S. Jasper, Pleasantville
George LeSar, Jr., Lancaster

FULTON COUNTY
John A. Billows, Delta
Conreys B. Relfe, Wauseon

GEAUGA COUNTY
Wolfram G. Locher, Chardon

GUERNSEY COUNTY
Earl J. Farrell, Cambridge

HAMILTON COUNTY
Robert W. Buckley, Cincinnati
Eugene J. Burns, Cincinnati
John B. S. Campbell, Cincinnati
Donald G. Casterline, Cincinnati
Virginia M. Esselborn, Cincinnati
Marjorie Ann Grad, Cincinnati
Raymond H. Hellman, Jr., Cincinnati
Richard A. Jubelirer, Cincinnati
Henri LeClaire, Cincinnati
Arthur W. Nadler, Cincinnati
Aaron W. Perlman, Cincinnati
Joseph Ransohoff, Cincinnati
Marc J. Reardon, Cincinnati
Milton F. Reiser, Cincinnati
E. Vernon Smith, Cincinnati
John L. Tyler, Ivorydale
Robert P. Ulrich, Cincinnati

HANCOCK COUNTY
Richard Fishell, Findlay
David H. Greegor, Findlay

HARDIN COUNTY
Robert A. Thomas, Ada

HENRY COUNTY
John R. Schlereth, Napoleon

HURON COUNTY
John V. Emery, Greenwich

JACKSON COUNTY
Earl H. Stanley, Jackson

KNOX COUNTY
Delbert C. Schmidt, Mt. Vernon

LAWRENCE COUNTY
Vallee W. Blagg, Ironton

LORAIN COUNTY
Daniel W. Kramer, Oberlin

LUCAS COUNTY
Lintner E. Clark, Toledo
Lyle W. Kahler, Toledo
H. F. Mignerey, Jr., Toledo
Anna Mae Newton, Toledo
Johnston F. Osborne, Toledo
George T. Rich, Toledo
R. P. Whitehead, Toledo

MAHONING COUNTY
Herbert B. Hutt, Youngstown
A. E. Rappoport, Youngstown

MARION COUNTY
John E. Imbody, Marion

MEDINA COUNTY
Herbert F. Cowgill, Wadsworth
Guy S. Peterson, Wadsworth

MERCER COUNTY
Eugene J. McLaughlin, Ft. Recovery

MONTGOMERY COUNTY
Stewart Adam, Dayton
John T. Bickmore, Dayton
Sydney E. Dinkin, Dayton
Cecil Giscombe, Dayton
Frederick J. Grigsby, Dayton

MUSKINGUM COUNTY
Peter A. Fomenko, Dresden
Robert B. Morrison, Zanesville
L. D. Quick, Zanesville

PAULDING COUNTY
Jean-Maurice Poitras, Antwerp

PERRY COUNTY
Alton J. Ball, New Lexington
Frank R. Clemson, Thornville

PORTAGE COUNTY
Myrtle Collins-Dineen, Kent

PUTNAM COUNTY
Arthur P. Daniel, Ottawa

RICHLAND COUNTY
Robert J. Peirce, Mansfield
Elizabeth Reed, Butler

ROSS COUNTY
Buell L. Ashmore, Chillicothe

STARK COUNTY
Frank O. Goodnough, Massillon
James C. Hays, Canton
Wm. A. Lieser, Canton
John C. McDonald, Massillon
Keith C. Noble, Alliance
Sol Scholnik, Canton
Robert E. Sumner, North Canton
John M. Tondra, Canton

TRUMBULL COUNTY
Charles A. Anderson, Warren
Donald A. Miller, Warren
Rex E. Whiteman, Bristolville

TUSCARAWAS COUNTY
George W. Johnston, Jr., New Philadelphia

UNION COUNTY
Walter R. Burt, Milford Center

VAN WERT COUNTY
Vernon E. Duckwall, New York, N. Y.

WASHINGTON COUNTY
Donald E. Hughes, Marietta

WAYNE COUNTY
Lincoln L. Moore, Wooster
W. M. Watson, Wooster

WILLIAMS COUNTY
Victor L. Boerger, Edgerton

Third District General Practitioners Organize, Elect Officers

Dr. J. R. Jarvis, Van Wert, was elected president of the Third Ohio District Chapter, American Academy of General Practice, at the first scientific meeting held at the District Tuberculosis Hospital, Lima, in December. Other officers are Dr. C. W. Berry, Wapakoneta, president-elect; Dr. Guy Noble, St. Marys, treasurer, and Dr. B. W. Travis, Bluffton, secretary.

More than 20 members and guests were present for the opening meeting. Officers described it as very instructive and interesting and expressed confidence that the organization was off to a good start and promising future. A luncheon meeting was held at the Shawnee Country Club.

The upward trend in the annual number of deaths from accidents subsided somewhat in 1948. The estimated number in that year was 99,000, a drop of some 600 from the 1947 figure.



To bring the tube head under the table, simply release the lock-lever.



radiography

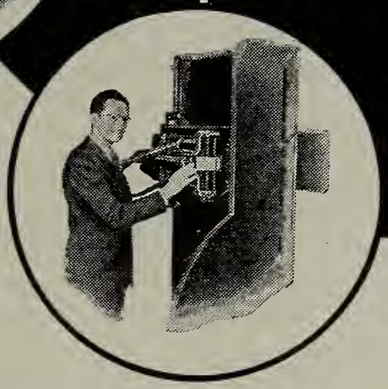
The counterbalanced tube arm swings around freely, safely.

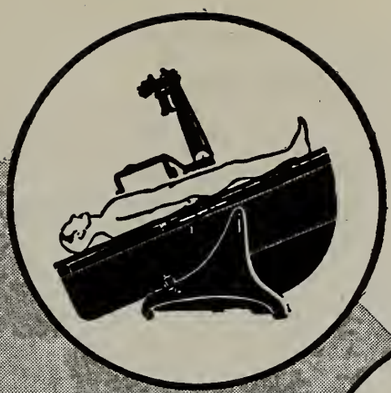
Tube head passing end of table with ample clearance.



fluoroscopy

Tube now locked in fluoroscopic position, table elevated vertically.



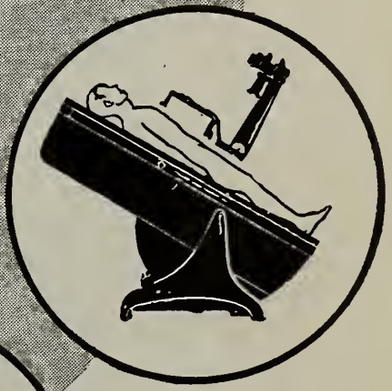


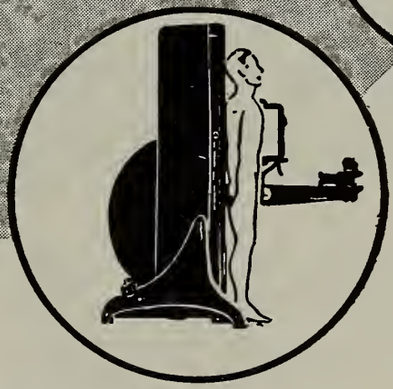
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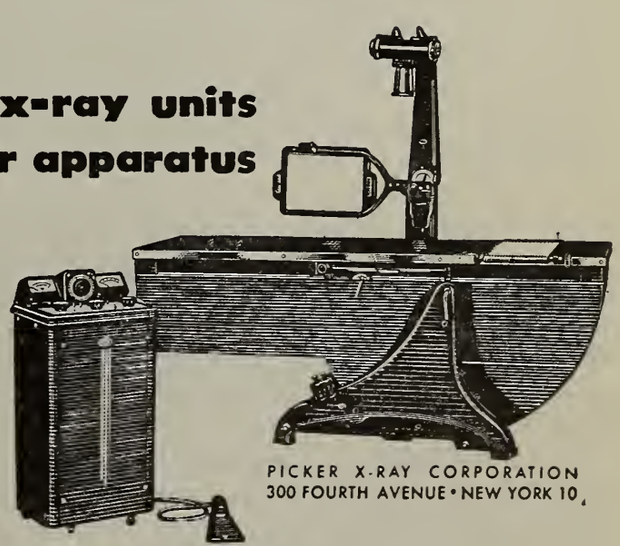
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Do You Know? . . .

Dr. Ralph M. Waters, a native of Ohio, and graduate of Western Reserve University School of Medicine, 1912, voluntarily retired as professor of anesthesia at the University of Wisconsin Medical School on January 1.

* * *

The American Cancer Society will conduct its annual drive in April, which is to be National Cancer Control Month. The minimum goal is $14,500,000. Charles F. Kettering will direct the campaign.

* * *

The American Review of Soviet Medicine has suspended publication, "for reasons which are so obvious we need not elaborate on them," according to Dr. Henry E. Sigerist, consultant editor.

* * *

The first cerebral palsy center of its kind in the nation will be opened next fall at Bowling Green, under the co-sponsorship of the State University there and the Ohio Society for Crippled Children.

* * *

The International and Fourth American Congress on Obstetrics and Gynecology will be held at the Hotel Statler, New York City, May 14-19.

* * *

In recognition of his outstanding service to Finland, principally as vice-consul, Dr. P. J. Collander, Ashtabula, has been cited by President Juho K. Paasikivi of Finland as a Knight of the Order of White Rose.

* * *

Dr. John J. Phair, Louisville, Ky., a graduate and former member of the faculty of the University of Cincinnati College of Medicine, returned to the staff Feb. 1 as professor of preventive medicine.

* * *

More than 300 medical college faculty members and premedical students from throughout the state met on the Ohio State University campus, Feb. 19, for an open conference on medical education. The meeting was sponsored by Alpha Episilon Delta, national premedical honor society.

* * *

Dr. Joseph Morton, associate professor of radiology at Ohio State University, was designated the "outstanding young man of Franklin County for 1948," by the Columbus Junior Chamber of Commerce. Dr. Morton was cited for his "studies and pioneering in the field of treatment of cancer with radioactive cobalt." The annual award is restricted to the most outstanding contribution to human welfare in Franklin County and is limited to men under 36 years old.

There were 2,064 tuberculosis deaths in Ohio in 1948, as compared with 2,362 in 1947 and 2,555 in 1946.

* * *

Dr. Alan Moritz, professor of legal medicine at Harvard University Medical School, will be director of the Institute of Pathology of Western Reserve University, Cleveland, beginning August 1. He will succeed Dr. Howard T. Karsner, who is retiring after 20 years as head of the institute.

* * *

Every patient-room at the Cleveland University Hospitals soon will be equipped with piped-in oxygen for use in medical emergencies.

* * *

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, and Chairman of the Medical Society Executives Conference, spoke on "State-Side View of the National Campaign," at a meeting of state medical society and American Medical Association officials held at Chicago, February 12, to discuss the educational campaign of the A. M. A.

* * *

Hospital Care Corporation, Cincinnati, paid 92.5 per cent of its income in 1948 for the hospitalization of Blue Cross members. Only 7.4 per cent of income was used for operating expenses.

* * *

The executive committee of Pilot Club International, an organization of Business and Professional Women, has authorized its 300 local clubs to work actively against legislation which would provide for any form of National Health Insurance.

* * *

The median age of all living physicians in the United States declined from 45.8 years in 1940 to 44.4 years in 1948.

* * *

Two of the nation's biggest organizations—the American Bar Association, with a membership of 41,000, and the American Farm Bureau Federation, which has a membership of 1,325,826 farm families—went on record recently as definitely opposed to any form of compulsory sickness insurance sponsored by the government.

* * *

Construction will begin soon on a modern laboratory and clinic for large-scale production and study of BCG. The project, which will be known as the Institution for Tuberculosis Research, is a joint enterprise of the Chicago Municipal Tuberculosis Sanitarium, the University of Illinois, and Research Foundation.

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***Reprints on request:*

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

Hospitals Reject Ewing Proposal . . .

American Hospital Association Offers Constructive Suggestions for Health Program, But Refuses To Support Compulsory Sickness Insurance

WRITING in the January, 1949, issue of *Hospitals*, official publication of the American Hospital Association, Joseph G. Norby, president of the A. H. A., outlines the action of the Board of Trustees of that organization on December 11, in adopting "A National Health Program for America's Hospitals."

Mr. Norby points out that the A. H. A. reaffirms action taken in 1944 when it offered a constructive "national health program"; tells of conferences held with Federal Security Administrator Ewing; and reports that the trustees of the A. H. A. have informed Ewing that they will have no part of his proposal for compulsory insurance.

Following are excerpts from a resolution on this question which was adopted on December 11 by the A. H. A. Board of Trustees:

> "Resolved, that the American Hospital Association reaffirms its program for the improvement of the quality and distribution of hospital care, and be it further
>
> "Resolved, that the American Hospital Association urge legislative attention to provision of assistance for those unable to meet the whole cost of medical and hospital care; and for the provision of public health services and for more adequate numbers of trained personnel in the health field, and be it further
>
> "Resolved, that the American Hospital Association reaffirms its conviction that a program of federal compulsory health insurance is inadvisable at this time; and that such a program is bound to be detrimental to the continuous improvement of the quality of care for the American people."

Among the pertinent comments made by Mr. Norby in his article suggesting how improvements could be made in the health of the people without resorting to drastic and unsound measures, were the following:

"The Board of Trustees of the American Hospital Association, on December 11, 1948, reaffirmed the Association's program for improving the distribution of hospital care for the American people. This action was taken after careful study of the current situation in the health field, in politics and in the nation as a whole. It reemphasizes the Association's firm belief that its program adopted in 1944 is most likely to bring about an adequate distribution of high quality health services to the most people, and recognizes the need for a continuing and progressive program to meet these ends.

MEETING NEEDS

"Hospitals, operating as a public trust and in the public interest, are well informed of the true needs and desires of the people regarding hospitals and health. The public looks to the hospital primarily for adequate facilities manned by competent personnel and within its financial reach. The Association's program, which has been aggressively pushed, endeavors to do just that by:

> "1. Urging federal grants in aid for the construction of needed hospital facilities in areas which cannot provide them from local resources.
>
> "2. Aggressively supporting Blue Cross plans and the prepayment insurance principle as the best means of budgeting for the costs of hospital care for the self-supporting citizen and his family.
>
> "3. Insisting that government (local, state and federal) meet its responsibility by providing for the costs of care of those without personal resources to buy hospital care.

"When President Truman signed the Hill-Burton Hospital Survey and Construction Act on August 13, 1946, the first point in the Association's program for better care for the public was realized.

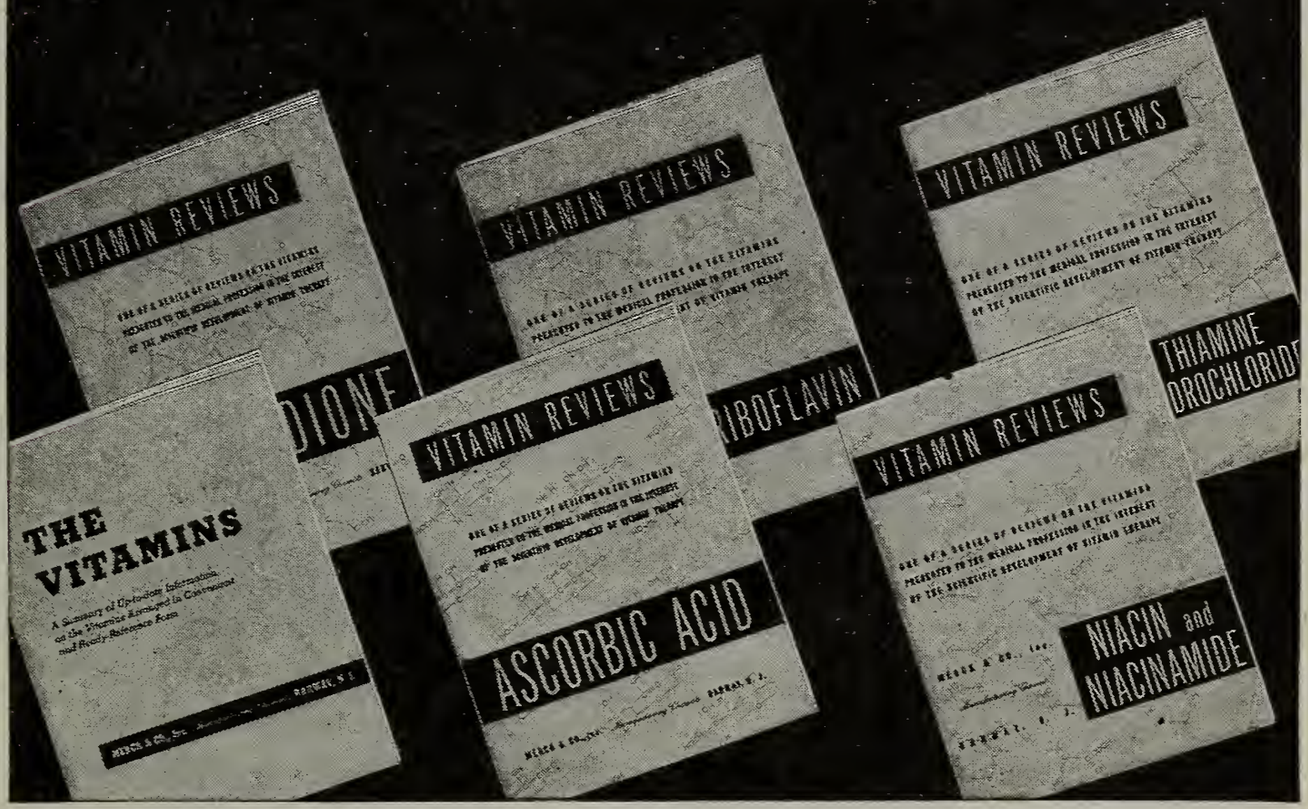
"Hospital support not only in the passage of this legislation but in working out the program has been fundamental to its success. Hospitals of the nation, working together through the Association, developed this widely acclaimed program which supplemented the best in the voluntary hospitals with government aid in order that there might be hospital facilities where needed to serve the American people.

"Hospitals recognize: That average care is not enough; that constant improvement in education, research and facilities must be carried on continuously if the high quality care the nation wants is to be achieved; that such care is costly, and here the government might accomplish much by supplementing present voluntary accomplishments. Currently, through government inertia, the most serious deficits are in public health personnel and other areas solely the responsibility of government.

"In the development and sponsorship of Blue Cross prepayment plans for budgeting for the

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- **Methods of administration.**
- **Clinical use in specific conditions.**

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costs of hospital care—which is the second part in the Association's program—hospitals have accomplished dramatic results. Since the first Blue Cross plan was established a decade and a half ago, enrollment has reached a total of more than 32,000,000 individuals and thousands more are added each day. Similar coverage by insurance companies brings the total to over 50,000,000 persons who have been relieved of the major costs of hospitalization. Medical care plans, more recently inaugurated, are receiving equal public acceptance and support.

BUDGETING COSTS

"Today, hospitals sponsor Blue Cross plans serving all of the 48 states, knowing that by this prepayment principle, they enable millions of employees and their families to budget for the costs of hospital care voluntarily and on a basis that enables the individual to choose his own doctor and hospital and meet the costs of the worst financial risk resulting from illness.

"To make Blue Cross benefits even more widely available to all segments of the population, there was formed during 1948 an organization of the Blue Cross plans which has for its purpose making enrollment available to large national groups of employees. This demonstrates that voluntary organizations are flexible, sensitive to popular needs and that they can be adapted to meet such needs as they develop.

"The third point, which refers to encouraging government assumption of responsibility on all levels—local, state and national—for financial assistance for the care of the needy, has been an important objective of hospitals. Government's responsibility for the care of those who cannot meet the costs of hospitals and medical care is not being adequately met. This fact accounts for much of the present financial difficulties of all hospitals—voluntary and governmental.

"During the last Congress this Association, together with the American Protestant Hospital Association and the Catholic Hospital Association, testified in support of proposed legislation for providing federal financial aid for those who cannot afford to pay for it. This proposed legislation was not enacted; however, hospitals and the Association will continue to strongly support measures aimed at providing for the costs of care for low-income groups.

"Proposals for federally controlling health care in the United States have been gaining momentum for a number of years. The latest effort in this direction was the report of Federal Security Administrator Oscar R. Ewing to President Truman on the 'Nation's Health.' It is expected that there will be renewed efforts to impose some over-all pattern of governmental regulation as set forth in the report upon the health field. Recognizing their responsibilities to maintain and expand high quality of service to their communities, hospitals repeatedly have expressed their concern—from the viewpoint of how such a program would affect hospital's ability to best serve the public—in all proposals for an all-inclusive health program which would supplant rather than supplement.

"In August of last year, the president of the American Hospital Association wrote to President Truman expressing this concern of hospitals. Mr. Truman's reply contained assurance that nothing he planned would interfere with the continued service of voluntary hospitals to their communities. In September, the presidents of the American Hospital Association, the Catholic Hospital Association, the American Protestant Hospital Association, and the Greater New York Hospital Association called upon Mr. Truman to discuss the practical implications of his reassurances. Mr. Truman agreed that the problem should be explored further and appointed Mr. Ewing as his personal representative for further discussions.

"The federal security administrator's report to the President has been accepted as expressing in broad terms the program of the administration. In addition to recommending the expansion of hospital facilities, an expanded public health service, and government aid for the indigent—which, for some years, has been a part of the action program of hospitals—Mr. Ewing also recommends a federal health insurance plan.

"Hospitals cannot agree on the basis of accomplished facts that a compulsory federal program of health insurance is wise or necessary. It was on the basis of this aspect of the report that hospital representatives met with Mr. Ewing on December 6. The great progress being made in increasing and expanding facilities, the continued growth of Blue Cross and prepayment plans and the need for a program of financial aid for the care of the needy, all being phases of hospitals' active program to provide the public with high quality care, were pointed out in the discussions with Mr. Ewing. On behalf of the best interests of the public, it was urged that consideration be carefully given to any program which may affect the American hospital system as it has developed to date and as the present plans and programs of hospitals' indicate that it will continue to progress and operate in the public interest.

"On the basis of facts and accomplishments, the representatives of hospitals advised the federal security administrator that voluntary hospitals, while in agreement with those aspects which would build constructively, would be unable to support his recommendation for compulsory health insurance.

"It would seem wise at this time to defer



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arguments, both 'pro' and 'con,' regarding any possible health legislation until such legislative proposals are viewed and studied in the best interest of the public. At that time, proposals for a federal health program can be weighed on their merits whether they will serve the people best.

"The Association believes more funds are needed in the health field and has urged and will welcome federal, state and local government funds in programs intelligently planned to supplement and strengthen the great accomplishments already attained in rendering high quality care to the public. No national program of national health insurance has yet been proposed which promises to do just that."

Summit Auxiliary Health Exhibit Draws 3,000 Visitors

Approximately 3,000 Akron citizens visited the Health Instruction Exhibit sponsored February 4 and 5 by the Woman's Auxiliary to the Summit County Medical Society. The Public Relations Department of the Ohio State Medical Association presented an exhibit contrasting the ethical practice of medicine with examples of "mechanical quackery!"

The Woman's Auxiliary promoted a similar program last year, and officers stated that plans were already under way to hold another next year. Success of the two-day exhibit was due to the efforts of Mrs. J. Paul Sauvageot, Auxiliary president, and the following committee: Mrs. R. G. McCready, chairman; Mrs. Noah Miller, co-chairman; Mrs. F. T. Moore, Mrs. E. W. Breyfogle, Mrs. William Gallagher, Mrs. Reuben Pliskin, Mrs. C. P. Widmeyer, and Mrs. Laurence Weinberger. The exhibit was housed in the spacious auditorium of the O'Neil Department Store, by courtesy of store officers.

Interest in the State Association's exhibit was indicated by the fact that visitors picked up and carried away with them approximately 8,000 copies of pamphlets containing information on various phases of health and medicine. Most of the pamphlets were prepared by the American Medical Association, and—as physicians familiar with these pamphlets know—carry the implicit message that the reader owes it to himself and to his family to see his family doctor when the need for medical attention arises.

The exhibit used by the Association was part of the American Medical Association's collection of "mechanical quackery." The collection contains a number of items of mechanical devices used by "quacks" during the past hundred years to defraud patients.

The Summit County Medical Society sponsored a booth prepared by a committee headed by Dr. A. S. McCormick, chairman of the Committee on Medical History. The exhibit emphasized the role of the Society in the health setup of Akron and vicinity.

Among other organizations represented by booths were the following: Board of Education, Tuberculosis Association, Blue Cross, Visiting Nurse Society, Y. M. C. A., City Health Department, Water Department, Police Department, Sanitation Department, Cancer Control League, Red Cross, Summit County Dental Society, Summit County Pharmaceutical Society, Boy Scouts, Children's Hospital, Peoples Hospital, City Hospital, St. Thomas Hospital, Barberton Hospital, Dairy Council, Barberton City Health Department, Akron Community Center, Goodwill Industries, Jewish Center, Girl Scouts, City Home and School League, County Home and School League, County Health Department, Y. W. C. A., Council of Social Agencies, Child Guidance Clinic, Akron Public Library and Altrusa Club.

The Ohio State Medical Association was represented at the exhibit by Mr. George H. Saville, public relations director, and Mr. Gordon Moore, also of the Columbus Headquarters Office.

Activities of the Editor

Dr. Jonathan Forman, Editor of *The Journal*, took part in the following recent activities:

He spoke before the Sunbury Lions Club on the occasion of its annual Farmers' Night.

He attended the annual meeting of the Ohio Forestry Association.

Before a Granville Inn meeting of the Newark Harmonious Club, at which husbands of members were guests, Dr. Forman spoke on "Your Health Is a Product of the Soil." Dr. Forman is vice-president of the national organization of Friends of the Land and is professor of the history of medicine at Ohio State University.

In January he spoke to members of the Grove City Garden Club and the Commercial Point Club on the subject, "Let's Think About Health When We Plant Our Garden." Husbands of members of both clubs were guests at the meeting.

Dr. Forman began the fourth year of the radio series on creative medicine over radio station WOSU. The series continues to bear the general title "Keep Your Health." Recent subjects covered by him on the program were: "Death in Retreat," "Laxatives Do Cause Irregularity," and "The Simple Life of a Germ."

At the third annual meeting of the Soil and Water Conservation Society of America in Cincinnati he spoke on "What Do We Know About the Relationship of Soil, Food and Health?"

Dr. Forman addressed a recent meeting of the South End Lions Club of Columbus.

He addressed the Ohio Farm Implement Dealers Association on "Health and Prosperity Come from the Soil."

WHEN

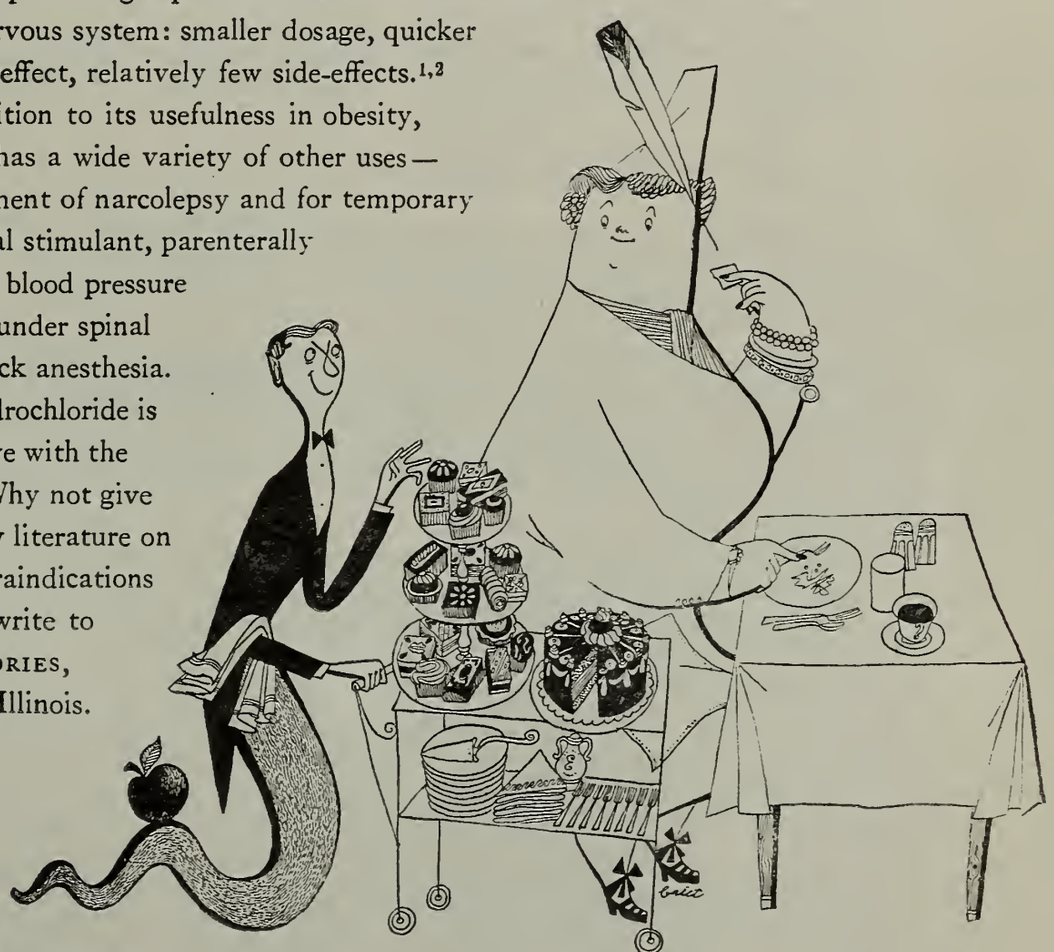
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1. Ivy, A. C., and Goetzl, F. R. (1943), d-Desoxyephedrine; A Review, War. Med., 3:60, January.
2. Davidoff, E. (1943), A Comparison of the Stimulating Effect of Amphetamine, Dextroamphetamine and Dextro-N-Methyl Amphetamine (Dextro-Desoxyephedrine), Med. Rec., 156:422, July.

Narcotic Order Forms . . .

Since Regulations for Filling Out Blanks Are Very Strict, District Supervisor Offers Some Suggestions for Physicians Placing Orders

MANY physicians reportedly have encountered difficulties in following specifications for filling out the required blanks when ordering narcotics. According to narcotic officials, reports from both retail and wholesale drug companies indicate that orders are often received with incorrect entries. Since narcotic regulations are very exacting, such incorrect entries cause undue delay, and often result in the blanks being returned.

The suggestions contained in this article for filling out the Narcotic Order Forms were prepared by a wholesale drug company and were distributed as an aid to physicians and pharmacists by the district supervisor of District No. 8, Bureau of Narcotics. The suggestions, with slight editing, are listed herewith:

1. **One of the commonest errors made is that of filling out the proper number of items at the bottom of the blank.** The customer usually makes this line out for the total number of packages he has ordered, instead of making it for the total number of lines of items he has ordered. For instance:

In an order for six packages of 12 ounce Papine HCl., one ounce of Codeine Phosphate Powder and four packages of 500 Empirin Compound & Codeine, the total number of items is three, not 11 items. **There are only ten item lines on a page, and each line is for one item,** regardless of the number of packages on that line. Therefore, if three item lines have been used, the order is for "Exactly three items."

2. **Another error is that where the tablets are packaged in 6's, 12's, 50's and 100's, the size of the package is sometimes left out,** although the Narcotic Form plainly states in the fourth column from the left, to state the number of pounds, ounces, grains, pills, etc., in each package. The customers should also specify if they want ampoules, pulvules, tablets or powder, and whether one cc. or two ccs.

3. **In the Name of Article column, should be placed the complete name of the item ordered.** For instance, in the case of Papaverine HCl. Ampoules, catalogue No. 423, all of this information should be indicated on the order.

In the case of Empirin Compound and Codeine 1/4 gr., 1/2, 1, or 1/8 grain, this is a long name and only one line is to be used, **so it can be abbreviated** to Emp. Comp. & Cod. 1/4. Or it may be spelled out, **using two lines within the one item line.**

4. Another common error, is that in ordering Codeine, the customer sometimes specifies three only one ounce, four, five or six ounces. **Not more than two ounces of Codeine may be ordered on any one order form.** This is in accordance with Treasury Department Bureau of Narcotics, Registrants Mimeographs 41 and 82, which specifies that "the limit which may be sold to a retail dealer pursuant to a single order form is two ounces or 1,000 grains of Morphine and two ounces or 1,000 grains of Codeine." **Two ounces of each drug may be sold on one order, but not more than two ounces of either.** This is by direction of the Commissioner of Narcotics.

5. **No blank may be altered, erased, added to or changed in any manner whatsoever.** If a blank is returned to the dealer because it is improperly made out or has been altered, the dealer should mark it "cancelled" and place it with his duplicate to keep his records intact.

6. **All blanks must be dated as of the date they are made out;** and not dated in advance.

7. **All blanks should be made out in duplicate with indelible pencil or ink in such a manner that the duplicate copy will be clearly legible in every detail.**

Dr. Humphreys Resigns From State Mental Hygiene Post

Dr. Edward J. Humphreys announced his resignation as acting commissioner of mental hygiene in the Ohio Department of Public Welfare effective in March. He has been with the Department for four years, and succeeded Dr. Frank Tallman as mental hygiene commissioner in September, 1947.

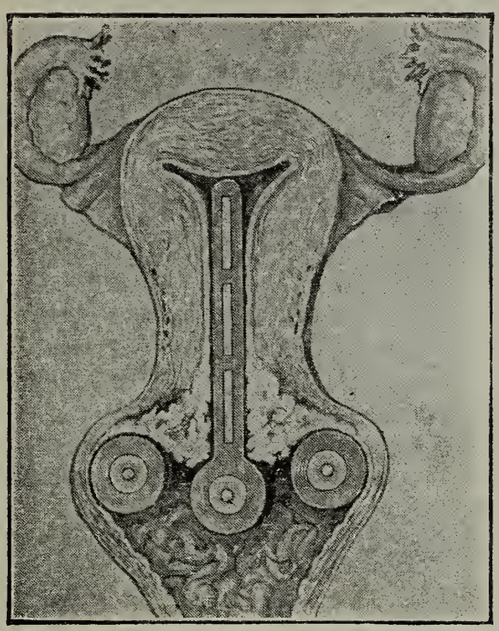
His resignation was tended to Judge John H. Lammeck of New Philadelphia, who succeeded Charles L. Sherwood as director of the Ohio Department of Public Welfare on January 10.

According to newspaper reports, Dr. Humphreys' resignation followed a disagreement with administrative officials on policies of the Department.

Dr. Humphreys announced that he had accepted a position as deputy commissioner in charge of hospitals and mental hygiene in New Jersey, his native state.

Estimated number of marriages in the U. S. in 1948 was 1,859,000. The total in 1947 was nearly 2,000,000 and the all-time peak, 2,300,000 in 1946.

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Licenses Granted . . .

State Medical Board Issues Certificates to 64 Doctors of Medicine Who Successfully Complete Required Examinations Given in December

LICENSES to practice medicine and surgery in Ohio were approved for 64 graduates of schools of medicine by the State Medical Board at its meeting held on January 25, Dr. H. M. Platter, secretary, announced. Those on the approved list took the examinations in Columbus, December 13-15, 1948.

Highest grade in the examinations was made by Dr. John C. Smith, Cleveland, a graduate of the University of Oregon, with an average of 90.3 per cent. Second highest grade was made by Dr. Malcolm D. McCampbell, Westerville, a graduate of Ohio State University, with 88.6 per cent; and third highest was taken by Dr. James A. Hardie, Columbus, with a grade of 88.1 per cent.

Five graduates of osteopathic schools and four additional applicants received certificates to practice osteopathic medicine and surgery. In addition, in the limited branches, certifications were awarded to 54 chiropodists, two mechanotherapists, eight chiropractors, 30 masseurs and two cosmetic therapists.

The following doctors of medicine were granted licenses:

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE:—Wayne Lyle Agey, Youngstown; William M. Anshutz, Columbus; Loren R. Baumgartner, Columbus; Robert T. Brown, Bloomdale; William W. Bryant, Senecaville; Rodney C. Caudill, Columbus; Neil W. Cummins, Columbus; Donald L. Gantt, Delaware; William Hamelberg, Jr., Chillicothe; James A. Hardie, Columbus; Dale A. Hudson, Columbus; Jerome Kimmelman, Toledo; Raymond J. Krause, Columbus; Paul W. Leithart, Columbus; William C. Love, Ironton; Robert E. Mayer, Cleveland; Malcolm D. McCampbell, Westerville; John F. McGarry, Columbus; Paul S. Metzger, Columbus; Howard A. Novell, Cleveland; Clarence B. Nyce, Bloomdale; Tracy G. Parks, Jr., Columbus; Seth S. Philbrook, Piqua; Gerald G. Schreiber, Youngstown; Arthur M. Simpson, Toledo; Jack O. Stoffel, Columbus; Julius M. Tesi, Yorkville; Lawrence C. Thompson, Columbus; David B. Thornburgh, Chillicothe; Leonard C. Tucker, Cleveland; Robert N. Whittenberger, Columbus; Irving Wikler, Columbus; Carolyn H. Ziegler, Columbus; Lester L. Zipser, Columbus.

WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE:—George D. Webster, Jr., Shaker Heights.

GRADUATES OF OTHER SCHOOLS:—Cornell University Medical College: Daniel R. Keating, Cleveland; Robert W. Tawse, Mansfield.

Hahnemann Medical College:—Frank L. Bevez, Lansing, Michigan; Ritchie Coons, East Cleveland; Richard H. Gollings, Akron; Richard P. McNelis, East Cleveland; Kevin B. O'Malley, East Cleveland; Cecil G. Piper, East Cleveland; Ralph A. Reilly, Cleveland; Richard C. Stevens, East Cleveland; Leo W. Zadinsky, Bridgeport.

Long Island College of Medicine:—Raymond R. Suskind, Cincinnati.

Loyola University School of Medicine:—Robert J. Navarre, Toledo.

Marquette University School of Medicine:—Madeline P. Dublin, Canton; Mary A. Kraft, Cleveland; Leonard H. Lerner, Cincinnati; William B. Rudemiller, Cincinnati; Aida T. Sereno, Cleveland.

Northwestern University Medical School:—John W. Wherry, Elyria.

Queen's University Faculty of Medicine, Kingston, Ontario, Canada:— Gordon H. Sprague, Cincinnati.

Syracuse University College of Medicine:—Marjorie H. Greene, Columbus; Harold A. Leader, Jr., Canton.

Temple University School of Medicine:—Harold V. Smith, Cuyahoga Falls.

University of Illinois College of Medicine:—Paul P. Parker, Columbus.

University of Minnesota Medical School:—Richard H. Schmidt, Indianapolis, Indiana.

University of Oregon Medical School:—John C. Smith, Cleveland.

University of Pennsylvania School of Medicine:—Robert E. Smith, Akron.

University of Wisconsin Medical School:—Edward E. Tennant, Cincinnati.

University of Montreal Faculty of Medicine:—Abraham J. Segal, Cleveland.

American Roentgen Ray Society To Meet In Cincinnati

The American Roentgen Ray Society will meet in Cincinnati at the Netherland Plaza Hotel the week of October 3, 1949. Dr. Raymond Walters, president of the University of Cincinnati, will address the opening session.

The Schools of Medicine of the University of Cincinnati, Western Reserve and Ohio State each will present a symposium of three papers. In addition to other scientific papers there will be scientific and commercial exhibits. Dr. U. V. Portmann of Cleveland, president-elect of the society, is arranging the program and will preside. Dr. Harold G. Reineke of Cincinnati is chairman of the local committee for arrangements.

Obstetrics and Gynecology

The International and Fourth American Congress on Obstetrics and Gynecology will be held at the Hotel Statler, New York City, May 14-19, under sponsorship of the American Committee on Maternal Welfare. Further information may be obtained by writing the chairman of the Congress at 24 W. Ohio St., Chicago 10.

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New A.M.A. 12-Point Program . . .

Medical Profession Offers Constructive "Evolutionary" Health Plan As Substitute for Proposed Drastic Compulsory Sickness Insurance

THE American Medical Association in mid-February announced a new, constructive 12-point health program.

Basic principles of the program have been developed over a long period of experience and advocated either by the A. M. A. or by component state associations during past years. These have been crystalized and formulated into a new program.

The 12-point program was approved and announced by the Board of Trustees after conferences with representatives of state associations and is offered as an alternative to the radical program now pending in the Congress. It is as follows:

1. **A Federal Department of Health**—Creation of a Federal Department of Health of Cabinet Status with a Secretary who is a Doctor of Medicine, and the coordination and integration of all Federal health activities under this Department, except for the military activities of the medical services of the armed forces.

2. **Medical Research**—Promotion of medical research through a National Science Foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

3. **Voluntary Insurance**—Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the states to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.

4. **Medical Care Authority with Consumer Representation**—Establishment in each state of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

5. **New Facilities**—Encouragement of prompt development of diagnostic facilities, health centers and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

6. **Public Health**—Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

7. **Mental Hygiene**—The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

8. **Health Education**—Health education programs administered through suitable state and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

9. **Chronic Diseases and the Aged**—Provision of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.

10. **Veterans' Medical Care**—Integration of veterans' medical care and hospital facilities with other medical care and hospital programs and with the maintenance of high standards of medical care, including care of the veteran in his own community by a physician of his own choice.

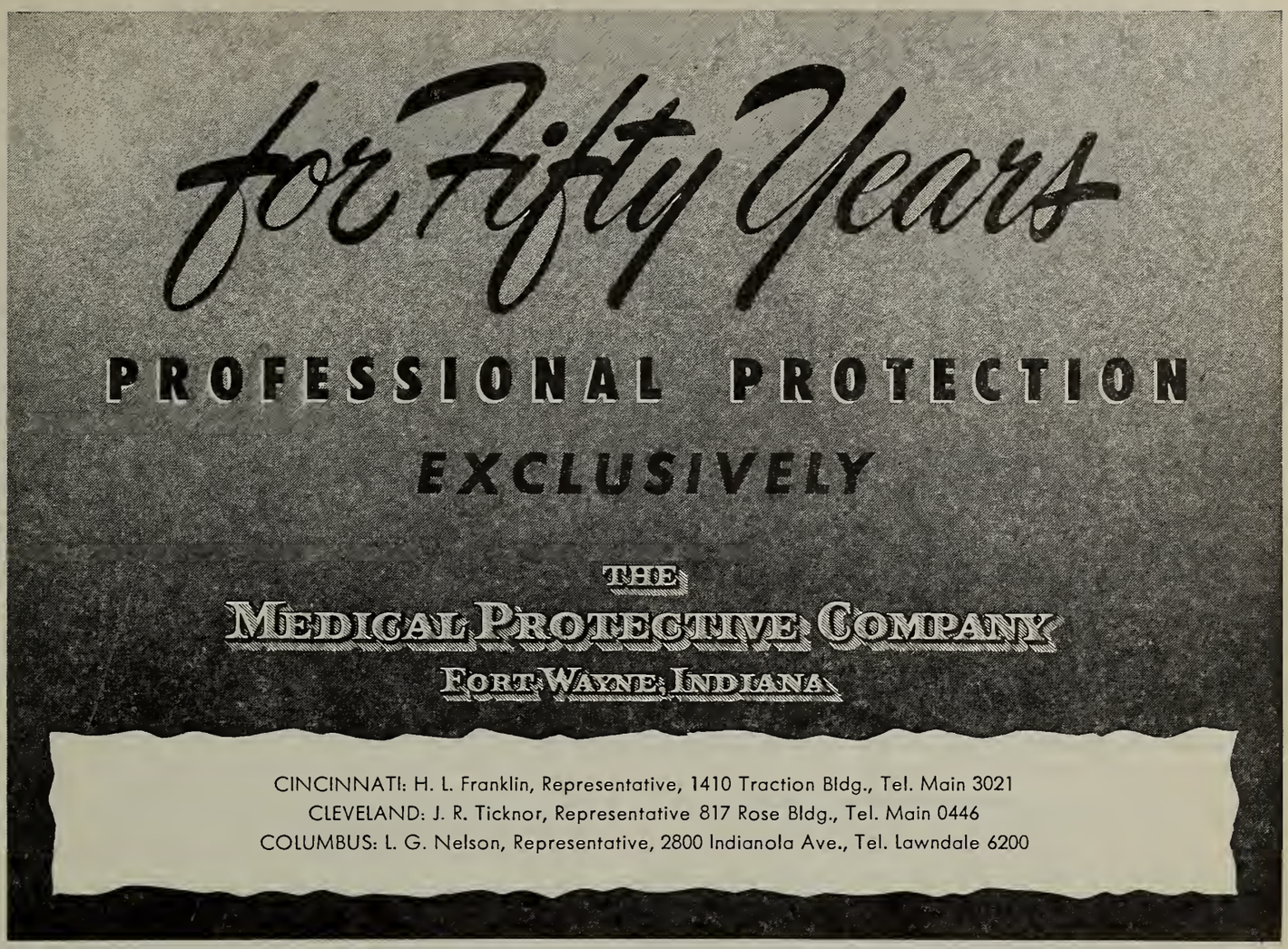
11. **Industrial Medicine**—Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, home and on the farm.

12. **Medical Education and Personnel**—Adequate support with funds free from political control, domination and regulation of the medical, dental and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care.

Annual Conference of County and State Officers, Committeemen

The annual conference of County Medical Society officers and chairmen of Legislative and Public Relations committees, as well as officers and committeemen of the Ohio State Medical Association, will be held in the Fort Hayes Hotel, Columbus, Sunday, March 20, beginning at 9:30 a. m.

Legislative and public relations matters of current vital interest to the medical profession will highlight this meeting. Personal invitations and programs have been mailed from the Columbus Office to officers and committeemen for whom this conference is planned.



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For the GENERAL PRACTITIONER

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In Memoriam . . .

Lewis Warren Beery, M. D., Canal Winchester; Long Island College of Medicine, Brooklyn, 1878; aged 97; died January 24. Dr. Beery retired from a long practice in Canal Winchester more than 12 years ago. He was one of the founders and president of the Peoples Bank of Canal Winchester, was a member of the Methodist Church and a member of the Masonic Lodge for more than 70 years. Surviving are a son, a daughter and a brother.

George Albert Canfield, M. D., Middletown; University of Michigan Medical School, 1946; aged 25; died January 26. Dr. Canfield was research assistant at Christ Hospital in Cincinnati. Surviving are his widow, an infant daughter, his parents and a sister.

Dwight Molyneaux Ervin, M. D., San Francisco, Calif.; University of Cincinnati College of Medicine, 1917; aged 63; died January 12. Dr. Ervin formerly was on the faculty of the University of Cincinnati College of Medicine. Surviving are his widow, a son, a sister and two brothers.

Charles Bonnell Hatfield, M. D., Bloomdale; Kentucky School of Medicine, Louisville, 1893; aged 87; died January 12; former member of the Ohio State Medical Association and the American Medical Association through 1928. Dr. Hatfield spent all of his years of practice in the Bloomdale area. He was a member of the Methodist Church. Surviving are a daughter, a son and two sisters.

Oliver L. Iden, M. D., Chillicothe; Eclectic Medical College, Columbus, 1899; aged 74; died February 6; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Ross County Academy of Medicine, 1942-43. Dr. Iden practiced medicine for more than 50 years and retired only within the last several months. He went to Chillicothe in 1914 from Somerset. He was a member of the Methodist Church, the Masonic Lodge and the Elks Lodge. Surviving are his widow, two sons and two brothers.

Bertha C. Lietze, M. D., Cincinnati; Laura Memorial Woman's Medical College, Cincinnati, 1897; aged 75; died January 15; former member of the Ohio State Medical Association and the American Medical Association through 1945. Besides engaging in medical practice, Dr. Lietze was active in civic and club work. She was a member of the City Council, and served three terms as president of the Women's Rotary Club. A sister survives.

Asa Calvier McClellan, M. D., Cincinnati; Meharry Medical College, Nashville, Tenn., 1909; aged 67; died February 4. Dr. McClellan practiced in Mississippi and Tennessee before coming to Cincinnati in 1937. Surviving are his widow, a son, a daughter and six brothers.

Sherman E. G. Pedigo, M. D., Athens; Starling Medical College, Columbus, 1895; aged 79; died January 21; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1948. Dr. Pedigo practiced medicine for more than 50 years. His practice was in New Marshfield until World War I when he went into the Army Medical Corps. After his military service he opened his office in Athens. Dr. Pedigo was a member of the Christian Church and several Masonic orders. He is survived by one daughter and his son, Dr. R. W. Pedigo, also of Athens.

James Walter Shopshire, M. D., Sidney; Baltimore Medical College, 1907; aged 67; died January 17; former member of the Ohio State Medical Association in 1933, and a former member of the American Medical Association. Dr. Shopshire retired from practice many years ago. He practiced in Oklahoma and Colorado and for a limited time in Athens. A sister survives.

Harold K. Shawan, M. D., Detroit, Mich.; Western Reserve University School of Medicine, 1909; aged 65; died January 11; member of the Michigan State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Surgery; member of the American College of Surgeons. Dr. Shawan was professor of clinical surgery, Wayne University College of Medicine. Surviving are his widow and two brothers.

Loren Gerald Strauss, M. D., Wooster; Western Reserve University School of Medicine, 1921; aged 53; died January 11, member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Strauss practiced in Wooster for 18 years. He was a member of the Lutheran Church and the Lions Club. Surviving are his widow, a son and his mother.

George Ross Taylor, M. D., Barberton; Western Reserve University School of Medicine, 1924; aged 50; died February 6; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Taylor practiced in Barberton and vicinity for 22 years. In addition to his medical practice, he was actively interested in agricultural and conservation developments. He was a member of the Summit County Board of Health, was a past-president of the Barberton Kiwanis Club and belonged to the Elks and Eagles lodges and the Methodist Church. Surviving are his widow, three sons and a daughter.



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Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLINTON

Dr. C. Rowell Hoffmann of Cincinnati spoke on "Diagnosis and Treatment of Uncomplicated Peptic Ulcer," illustrating his talk with slides, at the Jan. 4 meeting of the Clinton County Medical Society.

HAMILTON

The scheduled scientific program of the Academy of Medicine of Cincinnati for April and May includes the following features:

April 5—Dr. George W. Thorne, Harvard University Medical School; "The Function of the Adrenal Glands."

April 19—Dr. Harry Gold, Cornell University; "Management of Congestive Heart Failure."

May 3—Dr. Erich Lindemann, Harvard University Medical School; "Some Psychological and Social Factors in Severe Medical Illness."

May 17—Dr. Robert E. Gross, Harvard University Medical School; "Some Problems in Pediatric Surgery."

"Uses and Misuses of the Sex Hormones" was the subject of an address by Dr. Willard O. Thompson, University of Illinois College of Medicine, at the Feb. 15 meeting of the Academy.

HIGHLAND

Dr. Clifford G. Foor, Hillsboro, is the new president of the Highland County Medical Society. Other officers are: Dr. John G. Anderson, Lynchburg, vice-pres.; Dr. Robert G. Claeys, Lynchburg, secy.-treas.; Dr. J. Martin Byers, Greenfield, delegate, and Dr. Anderson, alternate.

WARREN

Members of the Warren County Medical Society elected the following officers who took office on Dec. 7: Dr. Orville L. Layman, Franklin, president; Dr. John E. Sharts, Franklin, vice-pres.; Dr. Arch D. Harvey, Lebanon, re-elected secy.; Dr. Mary L. Cook, treas.; Dr. Layman, delegate, and Dr. J. A. Nock, Franklin, alternate.

Second District

(COUNCILOR: H. C. MESSENGER, M. D., XENIA)

Dr. Forrest E. Lowry, president of the Second Councilor District Medical Society, called a meeting of officers and delegates of component medical societies for the evening of Feb. 16 in the Miami Hotel, Dayton. The purpose of the meeting was to discuss matters of importance, including legislation affecting the profession and items to be discussed at the coming Annual Meeting of the Ohio State Medical Association.

Other officers of the society are: Dr. M. D. Prugh, Dayton, vice-president; Dr. William H. Manning, Dayton, treasurer, and Dr. G. A. Woodhouse, Pleasant Hill, secretary.

CLARK

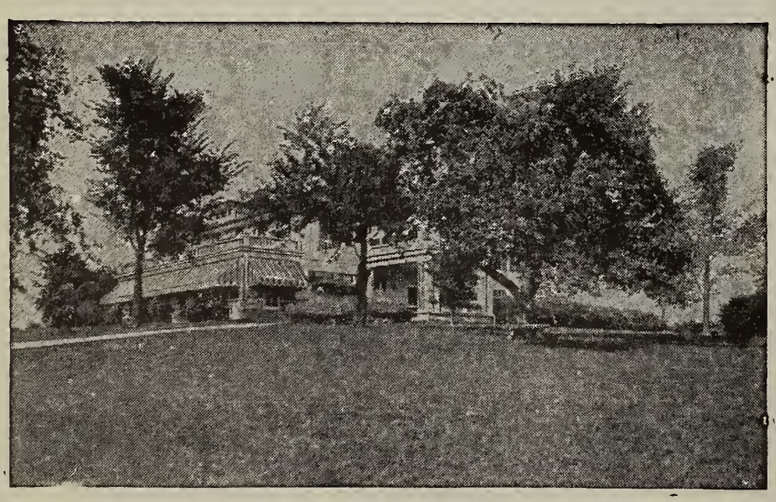
Dr. Allan C. Barnes, Ohio State University College of Medicine, Columbus, spoke on "Present Day Use of Sex Hormones in the Gynecological Field," at the Jan. 17 meeting of the Clark County Medical Society.

DARKE

"Dermatitis of the Hands" was discussed by Dr. John J. Shea of Dayton at the Jan. 18 meeting of the Darke County Medical Society in Greenville. Dr. Roger M. Gove, Piqua, spoke on "Psychiatric Problems" at the Feb. 15 meeting.

MIAMI

The Miami County Medical Society and the Shelby County Medical Society held their semi-annual joint meeting in Piqua on Jan. 6 with the Miami members as hosts. Dr. A. T. Bunts of Cleveland spoke on the subject, "Diagnostic Problems of Spinal Cord Tumors." Dr. R. E.



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Pumphrey of Dayton spoke on the subject, "Polypoid Disease of the Colon and Rectum," at the Feb. 4 dinner meeting of the society at the Stouder Hospital in Troy. Dr. D. F. Deeter of Troy, president, announced appointment of committee members, whose names were published in the society bulletin.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

HANCOCK

Dr. Lena S. Enright, Findlay, took office as president of the Hancock County Medical Society in January. Other officers are: Dr. Harold K. Treece, Arlington, vice-pres.; Dr. Thomas R. Shoupe, Findlay, re-elected secy.; Dr. Donald R. Brumley, Findlay, treas.; Dr. Frank M. Wiseley, Findlay, delegate, and Dr. Enright, alternate.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

Officers of the Academy of Medicine of Toledo and Lucas County for the year are: Dr. Foster Myers, president; Dr. Eugene A. Ockuly, vice-pres.; Dr. Carl H. Bayha, re-elected secy.. and Dr. W. W. Alderdyce, treas. All are of Toledo.

PUTNAM

The subject discussed at the Jan. 4 meeting of the Putnam County Medical Society was "Cardiac Disorders," with Dr. Homer G. Deerhake of Lima as guest speaker.

SANDUSKY

New president of the Sandusky County Medical Society is Dr. H. K. Shumaker, Bellevue, president; Dr. Forest R. Yohe, Bellevue, vice-pres.; Dr. F. D Crosby, Bellevue, secy.-treas.; Dr. H. L. Keiser, Fremont, delegate, and Dr. W. E. Brown, Clyde, alternate.

WILLIAMS

Dr. Joseph A. Maxwell, Montpelier, was re-elected president of the Williams County Medical Society for 1949. Other officers are: Dr. Paul G. Meckstroth, Bryan, vice-pres.; Dr. John R. Riesen, Bryan, re-elected secy.-treas.; Dr. H. W. Wertz, Montpelier, delegate; and Dr. H. R. Mayberry, Bryan, alternate.

WOOD

Members of the Wood County Medical Society were hosts to the Fourth Councilor Chapter of the American Academy of General Practice on Jan. 20 at Bowling Green. Seventy-five physicians were present and heard an address by Dr. Edward J. McCormick, Toledo, member of the Board of Trustees of the A. M. A., on the subject, "The Health of America." Dr. McCormick's

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talk was a discussion of the basic fallacies and dangers of the projected national health insurance program.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

The Board of Directors of the Academy of Medicine of Cleveland approved the action of its officers in extending to the American Medical Association House of Delegates an invitation for the A. M. A. to hold its 1950 Interim Session in Cleveland.

Dr. David A. Chambers and Dr. John D. Osmond, Jr., were re-elected president and secretary-treasurer respectively of the Cleveland Academy of Medicine for 1949. Dr. F. A. LeFevre is the vice-president.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

COLUMBIANA

Officers elected by the Columbiana County Medical Society for 1949 are the following: Dr. C. J. Maxwell, Wellsville, president; Dr. A. S. Fisher, East Liverpool, vice-pres.; Dr. M. C. Hanysh, Lisbon, secy.-treas.; Dr. P. H. Beaver, Leetonia, delegate; and Dr. J. A. Fraser, East Liverpool, alternate.

MAHONING

Dr. Robert H. Broh-Kahn, University of Cincinnati College of Medicine, spoke on "Some Speculations Concerning the Biology of Rheumatic Fever" at the Jan. 18 meeting of the Mahoning County Medical Society.

PORTAGE

"Diseases of the Newborn" was the subject discussed by Dr. James G. Kramer, Akron, at the Feb. 3 meeting of the Portage County Medical Society.

SUMMIT

Guest speaker at the Jan. 4 meeting of the Summit County Medical Society was Dr. Bayard T. Horton, Rochester, Minn., who spoke on the subject, "Headache."

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Dr. R. R. Renner of Cleveland spoke on "Safety Factors in Modern Gastric Surgery" at the Dec. 16 meeting of the Belmont County Medical Society.

CARROLL

Dr. W. S. Whiteleather, Minerva, took office as president of the Carroll County Medical Society on Jan. 1. Other officers are: Dr. John H. Murray, Carrollton, pres.-elect; Dr. Charles H.

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DEFIANCE, OHIO

Dowell, Carrollton, re-elected secy.-treas.; Dr. Samuel L. Weir, Minerva, delegate; and Dr. Glenn C. Dowell, Carrollton, alternate.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

FAIRFIELD

Dr. H. M. Amstutz, Lancaster, was elected president of the Fairfield County Medical Society for 1949 and Dr. A. B. Van Gundy, Lancaster, was re-elected secretary.

GUERNSEY

Guernsey County Medical Society officers for 1949 are the following: Dr. William L. Denny, president; Dr. Reo M. Swan, vice-pres.: Dr. James A. L. Toland, secy.-treas.; Dr. Robert A. Ringer, delegate; and Dr. J. D. Knapp, alternate. All are of Cambridge. Plans for establishing a cancer clinic in Cambridge were discussed at the Jan. 20 meeting of the society. There was also a discussion of the proposal to merge the city and county health departments. Dr. James A. L. Toland, Cambridge, presented a paper on "Newer Methods in Treatment of Bronchial Asthma." The Guernsey County Medical Society met Feb. 3 at the Berwick Hotel with Dr. William L. Denny presiding. The Rural Health Committee was scheduled to meet with the Finance Committee of Council to discuss merger of city and county health departments, after members expressed themselves in favor of the proposal. It was reported that $2,941 had been approved for use in establishing a cancer clinic in Cambridge. Twelve members of the society indicated that they would assist in operation of the clinic. Dr. Thomas S. Tonnous introduced Mr. Robert Conner who discussed "Income Tax Problems."

LICKING

New officers of the Licking County Medical Society who took office on Jan. 1 are: Dr. D. A. Skinner, president; Dr. James B. Johnson, vice-pres.; Dr. Lawrence H. Miller, re-elected secy.-treas.; Dr. G. A. Gressle, delegate, and Dr. Dale E. Roth, alternate. All are of Newark except Dr. Miller who is of Granville.

MUSKINGUM

Dr. Maurice G. Buckles of Columbus spoke on "Surgery of the Lungs" at the Feb. 2 meeting of the Muskingum Academy of Medicine in the University Club Rooms, Zanesville.

PERRY

Dr. W. D. Porterfield, Junction City, and Dr. H. F. Minshull, New Lexington, were re-elected president and secretary-treasurer, respectively of the Perry County Medical Society. Other officers are: Dr. James Miller, Corning, vice-pres.

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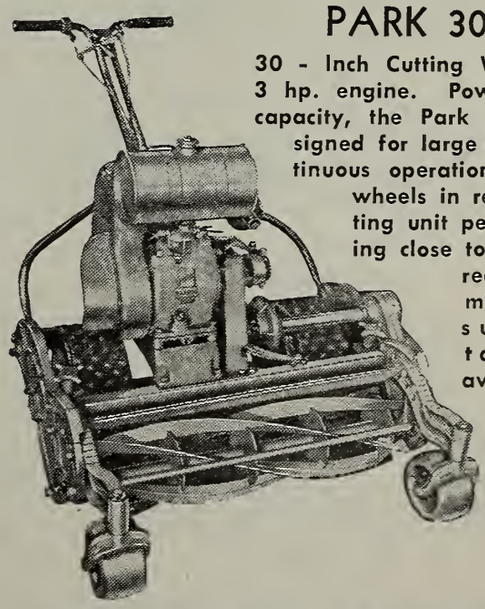
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and delegate; and Dr. Edgar D. Allen, Crooksville, alternate.

WASHINGTON

The following Marietta physicians were elected to office in the Washington County Medical Society: Dr. Donald S. Williams, president; Dr. Edgar Northrup, vice-pres.; Dr. Donald E. Hughes, secy.-treas.; Dr. Kenneth E. Bennett, delegate; and Dr. Williams, alternate.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

HOCKING

Hocking County Medical Society officers for the year are the following: Dr. J. Ward Doering, Logan, re-elected president; Dr. C. T. Grattidge, Laurelville, vice-pres.; Dr. Owen F. Yaw, Logan, re-elected secy.-treas.; Dr. Grattidge, delegate; and Dr. H. G. Southard, Logan, alternate.

SCIOTO

"Some New Concepts in the Management and Treatment of Diabetes," was the subject discussed by Dr. Norman O. Rothermich, Ohio State University College of Medicine, at the Feb. 14 meeting of the Hempstead Academy of Medicine in Portsmouth.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FRANKLIN

Columbus Academy of Medicine officers for 1949 are the following: Dr. Gilman D. Kirk, president; Dr. Grant O. Graves, vice-pres.; Dr. Thomas R. Curran, secy.-treas. Delegates are Dr. Graves, Dr. Warren G. Harding, Dr. Charles W. Pavey, Dr. Franklin C. Hugenberger, Dr. Phillip T. Knies, and Dr. Richard L. Meiling. Alternates are Dr. Howard R. Mitchell, Dr. Thomas E. Rardin, Dr. Anthony Ruppersberg, Jr., Dr. George F. Collins, Dr. William L. Pritchard and Dr. Clark P. Pritchett.

PICKAWAY

Dr. D. V. Courtright was re-elected president of the Pickaway County Medical Society and Dr. W. F. Heine was re-elected secretary-treasurer. Dr. Harry D. Jackson is vice-president; Dr. E. S. Shove, delegate; and Dr. Marion D. Gamble, alternate. Dr. Gamble is of Williamsport, the others are of Circleville.

UNION

Members of the Union County Medical Society, re-elected Dr. P. D. Longbrake, president, and Dr. A. M. Johnston, secretary-treasurer, of the Union County Medical Society. Other officers are Dr. F. C. Calloway, vice-pres.; Dr. E. J.

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Marsh, delegate; and Dr. Calloway, alternate. Dr. Marsh is of Broadway, the others of Marysville.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

RICHLAND

Members of the Richland County Medical Society elected the following officers for the year 1949: Dr. R. R. Crawford, president; Dr. R. D. Campbell, vice-pres.; Dr. F. M. Wadsworth, secy.-treas.; and Dr. P. A. Blackstone, delegate. All are of Mansfield except Dr. Blackstone who is of Bellville. Mrs. Frances W. Leggett, Mansfield, is designated corresponding secretary. The society and the active medical staff of the Mansfield General Hospital held a combined meeting on Jan. 20. Speaker on the occasion was Dr. Maurice A. Schnitker, Toledo, who spoke on "Newer Aspects of the Physiology of the Kidney."

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

ALLEN

Mrs. J. R. Tillotson was hostess to members of the Auxiliary to the Lima and Allen County Academy of Medicine for an all day meeting and luncheon, January 18. Twenty attended and the time was devoted to making slippers for the local hospitals.

ASHTABULA

Harland E. Bell, president of the Ashtabula County unit of the American Cancer Society, told the history of the organization, its accomplishments and its plans for the future, when he addressed the Woman's Auxiliary to Ashtabula County Medical Society. The group met for dinner at Hotel Ashtabula. Eighteen members from Conneaut, Geneva and Ashtabula were present. Mrs. S. A. Burroughs was in charge of arrangements.

BUTLER

Dr. Othilda Krug-Brady, assistant professor of psychiatry, College of Medicine, University of Cincinnati, addressed a joint meeting of the Butler County Medical Society and Woman's Auxiliary at Anthony Wayne Hotel in Hamilton. Her topic was "Common Emotional Problems in Children." The meeting began with a buffet supper. A program of interpretative dancing was enjoyed by the group during the supper hour.

CLARK

Presentation of the revised constitution and committee reports highlighted the meeting of the Woman's Auxiliary to the Clark County Medical Society held January 17 in the nurses' residence

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of Springfield City Hospital. Plans for holding a joint meeting with the Mental Hygiene Society of Springfield and Clark County in March were announced. Announcement was made that the local auxiliary had presented 30 subscriptions to *Hygeia* to county schools and that the organization has achieved 75 of the 100 points required by the state auxiliary. On February 10 the Nurse Recruitment and Fellowship Committee of this Auxiliary entertained 60 student nurses in the home of the chairman, Mrs. E. Paul Greenawalt. A buffet lunch was served using Valentine colors. A short program consisting of games, dancing and group singing was arranged by the committee.

ERIE

The Woman's Auxiliary to the Erie County Medical Society had a luncheon and meeting at the Business Women's Club. The President, Mrs. W. T. Fenker, introduced a new Auxiliary member, Mrs. Henry Schoepfle. The organization has admitted 11 new members during the past year and now has an enrollment of 46. The afternoon's guest speaker, Dr. David R. Lehrer, spoke on, "The Rh Factor in Pregnancy." Following the business session, the group viewed the films, "Wild Life in Ohio" and "Ohio's Mineral Resources." The Radio Health Program over WLEC Sandusky is an outstanding success. Each Tuesday morning at 10:30 one of the members of the Auxiliary or an Erie County doctor goes on the air. At present they are doing a new series called, "What Constitutes Adequate Medical Care."

FAIRFIELD

Dr. Lloyd Kersell, county health commissioner, was the speaker when the Woman's Auxiliary of Fairfield County Medical Society held a meeting January 12 in Hotel Lancaster Pine Room. The speaker gave an informative talk on the work of the county health department. Mrs. W. D. Monger presided at the meeting. Mrs. F. W. James, project chairman, announced that a series of transcriptions, "Before the Doctor Comes," are being presented each Wednesday over Station WHOK at 4:15 p. m. This series is being sponsored by the Woman's Auxiliary in cooperation with the Station.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine met on January 17 at the Columbus Gallery of Fine Arts. Mrs. Dana W. Cox reviewed the book, "Aging Successfully," by George Lawton.

LAKE

The Woman's Auxiliary to the Lake County Medical Society met at Lake County Memorial Hospital in January. Mrs. G. O. Hedlund, president, reported that slippers made by the auxiliary for patients at the hospital had been



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turned in. Mrs. Herbert Wells of Willoughby was named delegate to the convention in April. After the business meeting, the members made Valentine favors for a group of hospital patients.

LICKING

Active work of the Woman's Auxiliary to the Licking County Medical Society was stressed in the January business meeting following the dinner in Hull Place. Groups of members were assigned to the workshop periods in the home of Mrs. W. E. Shrontz where decorations were made for the "Hollywood Breakfast" benefit, planned to aid the March of Dimes. Mrs. Shrontz was elected to represent the auxiliary at the state convention to be held in Columbus in April.

LUCAS

The January meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County was held at the home for Crippled Children. Melissa Daily, superintendent of Opportunity House, was the speaker, preceding the tour of the building.

MARION

The Woman's Auxiliary to the Marion County Medical Society met at the Hotel Harding for luncheon. The guest speaker was Mrs. Beverly Kelly, an interior decorator from Delaware. This auxiliary is buying metal lockers for the private duty nurses at the City Hospital in Marion. It is also setting up a loan scholarship fund for laboratory technicians.

MONTGOMERY

The January meeting of the Auxiliary was held in the Auditorium adjoining the offices of the Montgomery County Medical Society. Following a short business meeting, Mr. Robert Watkins, of the Dayton Good Will Industries, talked on "Rehabilitation." Colored slides and a fine presentation made this worth-while community activity most interesting. An informal "visiting hour" followed.

OTTAWA

The January meeting of the Woman's Auxiliary to the Ottawa County Medical Society was held at the home of Dr. and Mrs. James Rhiel. After the meeting the members made gauze pads for hospital use. The doctors joined their wives for a social hour and refreshments later in the evening. Dr. and Mrs. George Poe had the December meeting when a Christmas party was an added feature. The hospital superintendent, Mabel Selin, was a guest at both meetings.

PICKAWAY

Dr. Horace B. Davidson of Columbus was guest speaker at the Woman's Auxiliary to Pickaway County Medical Society January meeting in Pickaway Country Club. Dr. Davidson presented

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PEDIATRICS—Intensive Course, two weeks, starting April 4.
DERMATOLOGY—Formal Course, two weeks, starting May 2.
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an interesting discussion on the "Rh Factor." A report from a committee of the Medical Society and the Auxiliary to assist in securing equipment for Berger Hospital was discussed.

ROSS

Seventeen members of the Woman's Auxiliary to the Ross County Academy of Medicine assembled for dinner February 3 at Allyn's dining room, Chillicothe. Mrs. Edwin H. Artman, president, conducted the business meeting. Mrs. John Traquair, guest speaker, discussed socialized medicine in England, or as it is called there, "national health service." An informal discussion by the members followed.

SANDUSKY

The Woman's Auxiliary to the Sandusky County Medical Society met for dessert in Cox's restaurant on January 19. Mrs. M. M. Riddell commented on the sending of a case of facial tissues to the detention home as a Christmas gift. Developments on proposed projects for the year were discussed. An invitation dessert card party was planned for February at the nurses home.

SCIOTO

The Woman's Auxiliary to the Hempstead Academy of Medicine made the front page in *The Portsmouth Times* on Saturday, February 5, with the headlines "Doctors' Wives Turn Holly into Oxygen Mask." This auxiliary maintains a Lend-Aid Bureau to assist the doctors in Scioto County to procure for their patients in the home, certain "hospital-type" articles needed for the home sick room that, for any number of reasons, may not be easily obtainable by the patient. All articles in the Lend-Aid Bureau, including the new portable oxygen mask with gauges, are supplied only on the request of the attending physician. This group raised money to purchase such a mask by selling holly during the holiday season.

SUMMIT

Mrs. E. Benjamin Gillette, the State President, was the honored guest at the annual Christmas luncheon of the Woman's Auxiliary to the Summit County Medical Society. The speakers' table was beautifully decorated by Mrs. James M. Ulrich. In an attempt to become better acquainted with other women's clubs in this county, the Auxiliary had a tea on January 11, to which members of federated women's clubs were invited. It was a delightful way to meet many civic minded women of the community.

TUSCARAWAS

The regular monthly meeting of the Woman's Auxiliary to the Tuscarawas County Medical Society was held January 13 at the home of Mrs. John Blinn, in New Philadelphia. Mrs. C. J. Miller, presided. Mrs. H. A. Coleman, superintendent of nurses at Union Hospital, reported on the book, "Nursing for the Future", by Esther L. Brown. Following the program, lunch was served by the hostess.

Buckeye News Notes . . .

Bellevue—Dr. H. K. Shumaker discussed the blood banks at a meeting of the Bellevue Kiwanis Club.

Cleveland—Dr. Saul Kottler recently opened his office in the Guardian Building for the practice of ophthalmology, after completing his training in ophthalmology at University Hospital in Cleveland.

Columbus—Dr. Richard H. Brooks has been named medical officer of the Ohio Penitentiary.

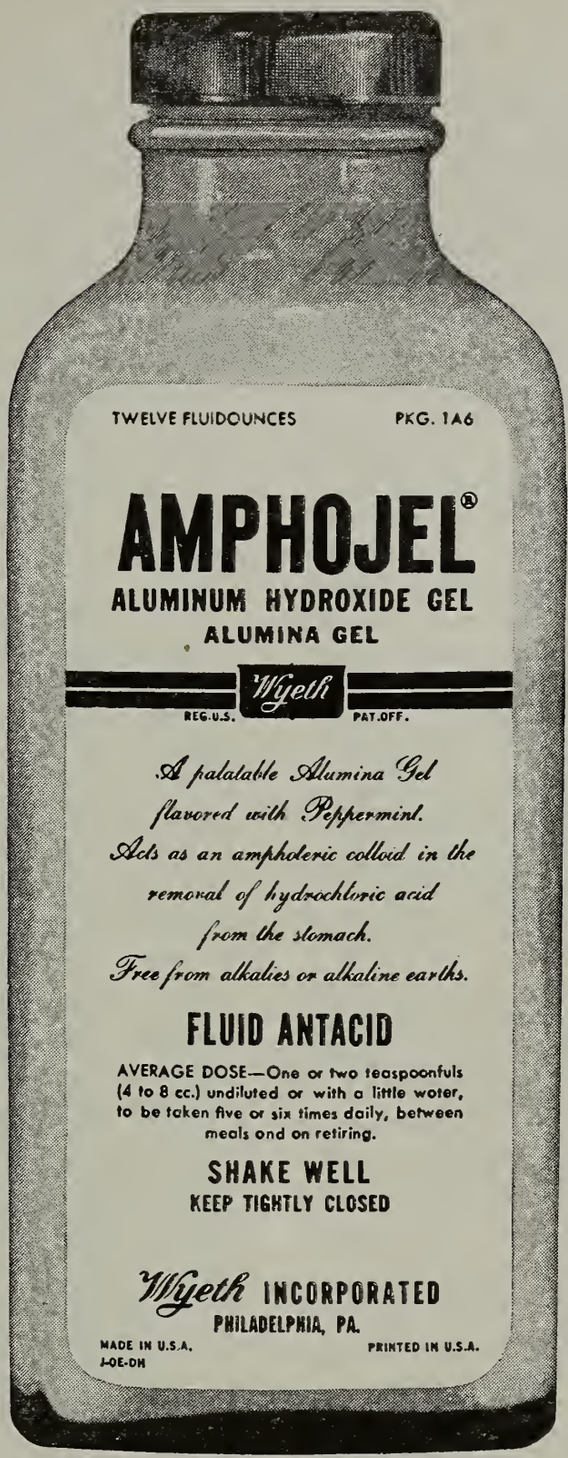
East Liverpool—Dr. Alex S. Fisher addressed the local Kiwanis Club luncheon meeting on the subject of "Infantile Paralysis."

Hillsboro—Dr. Charles M. Barrett, Cincinnati, addressed the Highland County Cancer Control Society at a meeting to which the public was invited.

Hubbard—Dr. Bernard M. Schneider spoke on the subject of cancer at a recent ladies' night meeting of the Exchange Club.







IN THE MEDICAL MANAGEMENT OF PEPTIC ULCER

The Physician's Bookshelf

By Jonathan Forman, M.D.

Motivation in Health Education, being the 1947 Health Education Conference of the New York Academy of Medicine, ($1.00. *Columbia University Press, New York City)* is a most timely book. When Organized Medicine is expending so much effort at Health Education, it is time to realize that most of it is not education because it does not motivate any one. Dr. Iago Galdston of the New York Academy, gives the history of the idea of motivation and the varied forms in which it appears in those systematized rationalizations which make up the story of philosophy and religion. Dr. W. W. Bauer of the A.M.A., describes the manifestation of the evolving idea in human conduct, showing the crude way in which fear and shame cause exaggerated phobia and equally exaggerated compulsive distortions of principles which in themselves are essentially sound. Dr. Lawrence Kubie, psychiatrist from Yale, shows the universal origins in childhood of the psychological force which distorts our unconscious attitudes to sickness and to health and how these buried residues of childhood experiences have been incorporated in the legends and myths which cluster around our ideas of hygiene.

Finally, Margaret Mead, ethnologist from the American Museum of Natural History, emphasizes that an understanding of the culture pattern, the prevailing attitudes towards body, towards reward and punishment, towards life and death, provides a frame work within which it is possible to develop an educational program which has a strong positive appeal.

Live Long and Like It, by C. Ward Crampton, M.D., (20 cents. *Public Affairs Pamphlet No. 139, 22 E. 38th St., New York City*) is full of good practical advice on longevity and geriatrics.

Blood's Magic For All, by Allen L. Blakeslee (20 cents. *Public Affairs Pamphlet No. 145, 22 E. 38th St., New York City*) deals with the relation of blood to national health. It explains in popular language what the Red Cross does with the blood it collects and why we should all give.

Your Coughs, Colds, and Wheezes, by Joseph D. Wassersug, M. D., ($2.95. *Wilfred Funk, Inc., New York City)* is another popular manual, well done, with sound advice. We like particularly the chapters on "Asthma—Pure and Simple" and "Asthma—Or What's the Real Diagnosis."

Your Life Is Their Toy, Merchants in Medicine, by E. M. Josephson, M. D., ($3.50. *Chedney Press, New York City)* is an attack on medical organizations and hospitals. It contains enough truth to mislead the uninformed reader, with its insistence that Medical Research, Medical Education, the A. M. A., American College of Surgeons, the New York Academy of Medicine—in fact, everyone, is running a racket except the author. He decides finally that the alternate solution of the cost of medical care is a solution of the problem of the economic organization of society, but here only extends his concept of sin in a wider circle. The book will interest all physicians dealing in public relations or psychiatry.

Common Skin Diseases, by A. C. Roxburgh, M. D., ($7.00. Eighth Edition. *Blakiston Company, Philadelphia)* is another book in "the general practice series." This edition introduces the discussion of the uses of penicillin, "sulphas" and D. D. T.—All in all, a handy, useful manual.

Your Life Is In Your Glands, by Herman H. Rubin, M. D., ($2.75. *Stratford House, New York City)* tells how the endocrines affect our mental, physical, and sexual health as well as our appearance, personality, and behavior.

Without War, by Thomas C. Gould. (Privately Printed. *Ward Ritchie Press, Los Angeles, California)* is a brilliant essay by a well-known California judge of the Superior Court of Los Angeles. The judge makes much of the limits to the subsistence levy which can be imposed by humanity upon the planet which it inhabits. "Quite obviously, this question is not to be solved piecemeal, assuring abundance to one continent while another is left in want. Neither is it to be shrugged off as a recrudescence of the Malthusian doctrine of overpopulation which the world has chosen to solve by declaring that it does not exist.

"In this contest the procreative urge must yield. This for the reason that, in the last analysis, the right to make life, like the right to take life, is a power to be exercised under the control of and for the benefit of the race as a whole." This, he concludes, might end wars and translate our fine humanitarian ideals into action.

Essentials of Gynecologic Endocrinology, by Garnder M. Riley, Ph. D., ($3.00. *Caduceus Press, Ann Arbor, Mich.)* is designed as a source of endocrine information for students, interns, and those of the medical profession who deal daily with vagaries of male or female gonadal function.

The Ciba Collection of Medical Illustrations, by Frank H. Netter, M. D., ($6.50. *Ciba Pharmaceutical Products, Inc., Summit, New Jersey)* is a compilation of those excellent paintings which Ciba has been sending you for a good many years. The method of presentation used in the Ciba collection is an excellent one for the busy practitioner. The book is being distributed at cost, which is certainly less than half.

Which Way Out, by C. P. Oberndorf, M. D., ($3.25. *International Universities Press, New York City)* is based on the experience of a psychiatrist. It tells the story of the representative cases which keep reappearing with different names and faces but with the same old problems.

Calm Your Nerves, by W. Beran Wolfe, M. D., ($1.00. *Garden City Publishing Company, Garden City, New York)* is a bit of popularly stated advice on how to prevent and cure nervous breakdown. The previous edition was called *Nervous Breakdown.* The book is packed with practical suggestions and encouraging illustrative cases.

Eating for Health, by Pearl Lewis, ($2.25. *Macmillan Company, New York City)* recognizes the increasing number of persons who no longer eat just to satisfy hunger. Emphasis is placed upon right eating habits. The author debunks the influence of those who have over-emphasized or misconstrued the advantages of certain edibles because of their enthusiasm or desire for personal gain.

Human Biochemistry, by Israel S. Kleiner, Ph. D., ($7.00. Second Edition. *C. V. Mosby Company, St. Louis, Missouri)* has gone through two editions and four reprintings of the first edition in three years. These facts speak for the popularity of this text by the Professor of the New York Medical College. This book will be especially appreciated by the "old-timer" who wishes to renew his chemistry because of the frequency with which it introduces chemical application.

Clinical Case-Taking, by George R. Herrmann, M. D., ($3.50. Fourth Edition. *C. V. Mosby Company, St. Louis)* continues to be an up-to-date guide for the study of patients by medical students. It covers, in an excellent fashion, the history-taking and physical examination or semiology of diseases in the various systems.

Contemporary Religious Jurisprudence, by I. H. Rubenstein ($2.50. *The Waldain Press, P. O. Box 97, Chicago)* is designed by its author to clarify and state the civil and criminal legal aspects of the major polemical tenets of fortune telling, faith healing, and pacifism. One or more of these tenets as exploited by each sect will always be in conflict in practice with public morals, public health, public welfare, and even national safety as seen by the majority of citizens in those cultures where the rules are laid down by a majority vote, i e., where the so-called democractic culture is operative. Most physicians will enjoy reading this book and find it most helpful in discovering the legal status of the Christian Science "Doctor."

Bio - Dynamic Farming and Gardening, by Ehrenfried Pfeiffer *(Anthroposophic Press, New York City)* was first published in America ten years ago. This was before this agronomist became an American citizen. The author's thesis is that the earth's fertility preserves itself wherever there is a harmonious distribution and relationship of forest, field, meadow, lake, river, and mountain; wherever the soil is treated intensively to the highest degrees, not, however, to its maximum capacity. He presents experimental studies that land, so treated, gives to animals and people an optimal quality of health which is reflected in increasing intensity even to the third or fourth generation.

Your Child Or Mine, by Mary Louise Hart Burton in collaboration with Sage Holter Jennings ($1.25. *Coward-McCann, Inc., New York City)* is the story of the cerebral-palsied child. In this fine work you will find clear, easily understood description of the types of cerebral palsy and their outcome with treatment.

The Renal Origin of Hypertension, by Harry Goldblatt, M. D., ($2.75. *Charles C. Thomas, Springfield, Illinois),* presents a summary in 119 pages of easy reading, of the present state of our knowledge of human and experimental hypertension.

Your Baby, by Gladys Denny Shultz and Lee Forrest Hill, M. D. ($3.50. *Doubleday and Company, Garden City, New York),* is by the contributing editor of *The Ladies' Home Journal* and a past-president of the American Academy of Pediatrics. It brings together, therefore, the great mass of information from trying to help thousands of war-mothers with their problems and a summary of modern medical thinking. A helpful manual that can be recommended to the new mother.

Control of Pain in Childbirth, by Clifford B. Lull, M. D., and Robert Hingson, M. D. ($12.00. Third Edition. *J. B. Lippincott Company, Philadelphia),* is a complete manual on this topic which has concerned physicians ever since anesthesia came into our work.

CORRECTION

Diagnostic Procedures for Virus and Rickettsial Diseases *(American Public Health Association, 1790 Broadway, New York City)* was erroneously quoted in the January issue at $1.00. The correct price is $4.00.

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JONATHAN FORMAN, M. D., *Editor*

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The Surgical Risk in Patients with Heart Disease

PAUL M. SPURNEY, M. D.

MOST of the literature concerning the risk involved in surgery of patients with cardiovascular disease has come from the internist, but with the increased inquiry by the surgeon into the physiochemical changes peculiar to the operative and postoperative periods, there is now accumulating evidence of circulatory, muscular, glandular, and other changes which will have important bearing on the care of these patients during this period.

The cardiologist considers the operative risk as based on the functional reserve of the heart, and the simplest and most comprehensive classification to be found is by Leaman as follows:

Grade I. Good Risk. Here are included patients in whom ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or chest pain; all cases of well compensated valvular disease except syphilitic heart disease with no renal involvement. (Class 1 of American Heart Association.)

Grade II. Risk fair with careful medical supervision and preoperative treatment. Here are grouped cases of beginning congestive failure and angina. These cases all show undue fatigue, palpitation, dyspnea, or chest pain on ordinary physical activity. (Classes 2 and 3 of American Heart Association.)

Grade III. Surgery Contraindicated. These patients show signs of cardiac insufficiency at rest or signs of heart infection. They cannot carry out any physical exercise without discomfort. Here are included severe angina, cases of cardiac decompensation with edema, severe dyspnea, and patients with marked reduction of the myocardial reserve.

To this might be added certain unpredictable risks as rheumatic heart with mitral stenosis, syphilitic heart disease, complete heart block and significant arrhythmias.

In the estimation of the risk to the individual patient the history is stressed as the most important single item, but final judgment as to the functional capacity of the heart should not be made until the data from physical examination, laboratory findings, plus X-ray and electrocardiographic studies are examined. The statement is frequently made in the literature that patients who can carry on normal daily activities without experiencing shortness of breath and chest pain can tolerate surgery with no more risk than the normal person, but the statement is also frequently found that all significantly diseased hearts undoubtedly have a reduction in cardiac reserve, and that they are adversely effected by complications of surgery. For these reasons, limited elective surgery is advised in good risks and only emergency operations in other groups, with the sound advice that any surgical procedure should be deferred until the condition of the patient is at its optimum.

While it is true that most operative cases with heart disease will survive with reasonable care, it is now evident, with the decreased mortality rates as a result of improved preparation and technique, that a large percentage

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Submitted July 21, 1948.

of the deaths today are of cardiac origin. Tanner and Cullen report a study of the autopsy material of 57 surgical deaths with 12 deaths of cardiac origin, or 21 per cent; 15 additional cases showed distinct involvement of the heart. Of the 12 cardiac deaths, only 7 were diagnosed as having heart disease which means more care must be exercised in diagnosis, particularly in the middle-aged groups. In all patients where surgery is contemplated there should be careful cardiac examination but even when heart disease is diagnosed our knowledge of treatment or what we may expect is still inadequate. The internist has no accurate method of judging the functional cardiac reserve nor of the imminence of decompensation; nor is there sufficient knowledge of the physiology of the operative and postoperative periods on which to base improved care of these patients. So much emphasis has been placed on returning the patient to normal before operation with the continuance of the same care after operation, that little attention has been paid to changes occurring with surgery which do interfere with the program as devised. With proper supervision of the heart, and with surgery fitted to the patient, plus cooperation of the internist, surgeon, and anesthetist, the patient will usually leave the operation room in good condition, but during the postoperative period, evidence of decompensation will be often found with occasionally severe failure and death. The problem resolves itself to the question as to the cause of the added strain to the heart, most evident in this latter period, and what can be done to avert it.

THE ANESTHESIA

Clinically, it is felt that emotion or excitement, fear, and pain make marked demands on the functional reserve of the heart, a point on which there can be no doubt; also that the anesthetic should be carefully chosen because of its possible effect on the heart and vascular system, with particular reference to the blood pressure changes. That the careful choice of anesthetic is necessary for the individual is obvious but there is not sufficient evidence to show that any anesthetic is generally contra-indicated. Nitrous oxide, ether, cyclopropane, and ethylene alone or in combination with local anesthetics, opiates, and barbiturates appear the best in so far as they show least effect on the blood pressure; in none of these has a deleterious effect on the heart muscle been noted. Spinal anesthesia should be used with caution because of its frequent marked lowering of the blood pressure.

During anesthesia, the frequent appearance of premature beats and occasional paroxysmal auricular fibrillations is noted which may have pathological significance. Much interest in the literature is focused on the marked fluctuations in blood pressure during surgery and in a short period afterwards; the significance of these fluctuations has not been determined except that a marked continued drop is significant of shock, but many cardiologists feel that these changes of blood pressure may effect the cardiac reserve, and that effort should be made to avoid them. Thorek stresses the observation of Clairmont that variations in vascular tonus and sudden fluctuations of blood pressure take place under narcosis which subject the circulation to a singularly heavy burden. Physiologically, changes in blood pressure are due to changes in the heart, in the blood vessels, or due to alterations in the blood; no one element can be disturbed without, in some way, affecting the functioning of the other elements. Much more information is necessary concerning alterations in the operative and postoperative periods before there can be any improvement of therapy. There is a scarcity of definite physiological data; the vital capacity shows a decrease for seven to fourteen days after surgery which may be lessened by early ambulation and a constant negative nitrogen balance is always found. In cats, evidence has been found of a decrease in glycogen storage in the liver, and an increase of acid metabolites in the heart muscle after operation. Snyder has shown in experiments in dogs that with ether there is a 76 per cent increase of cardiac output; in humans, immediately after surgery and before the patient is awake, there is a 41 per cent decrease persisting for from one to four days.

Cole, et al., in a study of postoperative convalescence state that we need more data on practically all physiological problems, as the cause of the extreme weakness often found after surgery more prevalent in middle age; whether the glycogen content of muscle or other tissue is altered, and if there is impairment of liver, adrenals, or other organs. They report the partial results of their studies of a series of 92 herniotomies and ten cholecystectomies as follows: (1) There is an impairment of liver function lasting two to five days which is worse with ether anesthesia and surgical complications; (2) a decline of the serum albumen with a maximum at the eleventh day; (3) a decrease of cholesterol and cholesterol esters lasting for several days more marked in the gallbladder group; (4) a decrease of cardiovascular function lasting for ten to twelve days. Many of these changes can be shortened by early ambulation and forced feeding. They point out that important discoveries cannot be expected without obtaining more data as to what functions are impaired and how.

THE SURGICAL PERIOD

The surgical period is a time of cardiac stress and may precipitate failure, so in the management of these cases all factors which may add to the strain as the type of surgery, the com-

fort of the patient, and the prevention of complications, should be given extra consideration. The operation should be simplified and shortened where possible, though, where emergency surgery of life saving need is necessary, it must be attempted even in bad risk hearts; with judgment and proper care there should be some success. The surgeon, internist, and anethetist must work together as a team for it is upon their combined ability that the outcome will largely depend. Any complication means increased risk. During operation, early signs of shock should be of great concern and quick termination of the procedure is indicated. The increased incidence of thrombi and emboli in these patients has led many surgeons to do immediate femoral ligations as a preventive measure.

Postoperative distension is to be avoided; besides the discomfort to the patient, pneumonia, atelectasis, and embarrassment of the heart may result, and early Wangensteen drainage and other therapy should be started early. Infection is a serious complication in heart disease, and early drainage should be instituted if found; prevention by antibiotics is the procedure of choice. Early ambulation and early feeding are very desirable.

From the time surgery is contemplated and until convalescence is well established, special thought should be given to the control of the blood volume, for a moderate sudden increase of fluid can cause failure. Plasma volume of the blood is increased by fluid intake, by extraction of water from the tissues, by the electrolytes, and may be affected by the lack of elimination in renal disease; in the well-prepared patient, fluid intake, the electrolytes, and elimination are of the most concern. As it is known that ill-advised oral feeding may damage the cardiac reserve, so it is obvious that the use of parenteral fluids is more dangerous, and should be used judicially in patients with heart disease.

When intravenous fluids are used, there is an increase of plasma volume proportional to the speed of the flow with an average of thirty to forty-five minutes before diuresis begins; the use of sodium chloride in isotonic solution will delay diuresis, tends to cause retention of the fluids, and is particularly harmful in renal disease. Except where there has been excessive loss of the chloride ions as in excessive perspiration and vomiting, saline is not necessary to maintain water balance and even then should be used with great caution. Excessive perspiration should be mimized by cool operating rooms, by the control of body temperature, and the relief of anxiety or pain of the patient; when there is vomiting early Wangensteen drainage should be started. The use of hypertonic glucose in water is recommended as universally as possible because glucose tends to promote diuresis, and water will filtrate easily.

Sufficient fluid must be given to prevent dehydration and insure elimination of waste products but the amounts necessary as noted in the literature have wide variations; 2000 cc. is sufficient in most instances. It is a wise precaution to give fluids slowly, in small amounts and repeated frequently if possible. Blood, plasma, and amino acids should be given with care both during and after the operation.

ILLUSTRATIVE CASES

Case 1. Mrs. C. W., aged 56, entered the hospital on January 30, 1945, with an extra-peritoneal tumor in the right lower abdomen and complaining of repeated gallbladder colic. She had a severe hypertensive heart disease, without evidence of failure, but with restricted physical ability. At operation on February 19, 1945, under nitrous oxide and ether, a retroperitoneal cyst was removed and a cholecystostomy performed, the patient returning to bed in good condition. Before operation her blood pressure was 230/120, pulse 88, respirations 18; during the operation both blood pressure and pulse fluctuated considerably, but shortly afterwards her blood pressure was 200/120, pulse 96, respirations 18. She was given 1000 cc. of 5 per cent glucose in saline intravenously, and on the following day 2000 cc. of glucose in water; no other parenteral fluids were used. The first two postoperative days her condition was good, but on the third day she went suddenly into acute failure from which she slowly recovered.

This seems to be a typical story when failure occurs; the patient returns to bed in good condition, with failure occurring two to three days later. It seems doubtful that the parenteral fluids played a part in failure in this instance. Improved care in this type of case should follow with a clearer understanding of the physiological facts of the operative and postoperative periods.

* * *

Case 2. Mrs. M. D., aged 60, entered the hospital on April 20, 1946, with a diagnosis of acute appendicitis; she had severe hypertensive cardiovascular disease with renal damage, without evidence of failure but with restricted physical ability. Drainage of an appendiceal abscess was done the same day under spinal anesthesia; marked variation of the blood pressure was noted at operation but the patient left surgery in good condition. That day the patient received 1000 cc. of 5 per cent glucose in saline; the next day 2000 cc. of glucose in saline was given and repeated the third day, after which the patient went into acute heart failure from which she slowly recovered.

In this case were three factors which could play a role in causing failure; the use of spinal anesthesia with wide blood pressure fluctuation, the constant use of saline with a possible increase in blood volume, plus infection.

* * *

Case 3. Mrs. T. G., aged 65, entered the hospital on July 27, 1947, with a strangulated right femoral hernia, distended, vomiting and a temperature of 40 degrees centigrade. She had a severe hypertensive heart disease with limited physical ability; on admission occasional rales were found

at both bases indicating imminence of failure. Wangensteen's drainage was started, and 1000 cc. of 5 per cent glucose in water was given; then under nitrous oxide and ether surgical, reduction of the hernia was performed. Her condition immediately after operation was fair but improved. She was given 1800 cc. of 5 per cent glucose in water the next day; on the second, 1000 cc. of 5 per cent glucose in water was given followed by a chill, coma, and death. No autopsy was obtained.

This case illustrates the difficult problem of acute surgery in severe cardiac disease without time for preparation. It also illustrates that these patients do usually stand the operative period well; any complication is much more serious than in the patient with a normal heart.

* * *

Case 4. Mrs. A. D., aged 54, entered the hospital with a strangulated umbilical hernia, vomiting and distended. She had hypertensive heart disease, with evidence of failure including ascites. Under nitrous oxide and ether, surgical reduction was quickly done; her condition was improved after operation. During the following days there were periods of labored breathing with noticeable pulmonary edema, and other periods of fairly normal breathing with the patient in good spirits. On the seventh day she died suddenly after a good day. No autopsy was obtained.

This represents a case of a "poor risk" heart in which surgery must be attempted; in this case there was hope that the patient would recover only to have sudden death occur. There is no choice in these cases but to attempt surgical cure.

* * *

Case 5. Mrs. E. S., aged 62, entered the hospital on September 9, 1943, with a diagnosis of carcinoma of the sigmoid flexure. Her general physical condition seemed excellent and no abnormality of the heart was noted. At operation on September 14, 1947, resection of the sigmoid was done. Convalescence was uneventful to the fourth day when the patient suddenly collapsed and died. Autopsy revealed the operative field in good condition; the heart showed marked sclerosis and narrowing of the coronary arteries with thrombosis of the left coronary vessel.

This case shows a need for closer and improved study of the heart, particularly of patients in this age group; there is also need of more information of the forces prevalent in the operation and postoperative periods causing circulatory changes leading to such accidents.

CONCLUSIONS

1. The cardiologist considers the operative risk of surgery on patients with heart disease as based on the functional cardiac reserve; there is no accurate method of judging the reserve nor the imminence of failure.

2. With lowered operative mortality, a significant percentage of deaths following surgery is noted as due to heart disease, and a more thorough examination of the heart is indicated preoperatively.

3. Most patients with heart disease will leave surgery in good condition, but may develop signs of failure postoperatively.

4. More data are needed on the many physiological changes of the operative and postoperative periods; improved therapy should follow an understanding of these changes.

5. In the management of these cases, the surgeon, internist, and anesthetist should work together as a team in preparation for surgery, during surgery, and after operation.

6. Limited elective surgery is generally advisable; surgery of life saving need should always be attempted.

7. Care should be taken to avoid complications of surgery in these patients.

8. Parenteral therapy, and particularly saline, should be used carefully.

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Reasons Given by 400 Patients for Not Drinking Milk

Reasons Given	No. of Patients	Per Cent
A dislike for milk	194	48
Indifference	64	16
"Disagrees"	53	13.2
Drink tea or coffee	15	3.7
Other hot beverages	4	1
Causes mucus	14	3.5
Fattening	13	3.2
Constipating	9	2.2
Doctor's orders	8	2
Allergic	9	2
Can't get it	6	1.5
Miscellaneous	11	2.7

When a patient says that milk "disagrees" with him he may state further that it bloats, makes gas, or nauseates, or causes indigestion, colitis, liver trouble or gallstones. Actually he may be allergic to milk. However, after a trial it is often found that milk is well tolerated.—R. M. Moose, M. D., San Bernardino; California Medicine, Vol. 70, No. 1, January, 1949.

The Diagnosis of Herniation of the Lumbar Intervertebral Disc (Nucleus Pulposus)*

ROBERT E. SLEMMER, M. D.

THE problem of the intervertebral disc is far from solution. A review of the current literature will reveal a divergence of opinion, not only as to the diagnosis, which at times is perplexing, but also as to the proper treatment.

Within recent months, articles on the diagnosis and treatment have appeared wherein opposite viewpoints have been presented. One gave the impression that all back pains are the results of disc pathology and can be diagnosed by the history and physical examination alone.[1] Another gave the impression that the history and neurologic examination were not enough, but when these were positive the diagnosis was then only a possible diagnosis until confirmed by roentgenographic findings using contrast media.[2] The positive preoperative diagnosis probably lies somewhere between these two extremes. The final diagnosis, however, is made at the time of operation.

Judging from the postoperative results in two large series of cases,[3] the treatment has been somewhat disappointing. It is believed, however, that early diagnosis and early treatment will yield better results.

The basis for the opinions and observations expressed here is the result of a review of the recent literature and a review of my own cases seen during two years in the naval service. All of the patients had complete medical, orthopedic, neurologic, roentgenographic and laboratory examinations.

The chief symptom and cause for the patient's seeking relief is pain. A careful evaluation of the symptoms and signs is a problem in itself. This is especially true in military cases. Unfortunately, there is no objective way to measure pain, so one must be on guard at all times. There are always those who are willing to undergo operative treatment to avoid or escape a situation which seems to them unbearable. This is also true in compensation cases. A careful history and evaluation of their symptoms, together with their objective findings, will uncover most of the functional cases. Occasionally, however, a psychiatric examination may be indicated.

The Author

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HISTORY AND SYMPTOMS

The majority (68 per cent) of cases of herniated disc give a characteristic history of trauma, the usual type being that which is sustained while lifting heavy objects when in an off-balance position, such as would occur in a a rotated and bent forward position. There follows a sudden "snap" in the back, which sometimes can be heard by the patient and is occasionally loud enough to be heard by those close at hand. In other cases, there is a "catch" in the region of the low back, when the patient's trunk is bent forward. It is extremely painful if not impossible for the patient to straighten up. This is coincident with or followed immediately by sudden acute back pain, which is believed to be due to the stretching of the posterior longitudinal ligament or rupture of the annulus fibrous, or both.

In approximately 90 per cent of the cases, the pain is at first confined to the back. In other cases, there is a definite irreducible posterolateral herniation of the nucleus of sufficient size to press directly upon the posterior nerve root. This gives rise to pain referred down the course of the sciatic nerve on the side wherein the herniation has occurred, and consequent numbness, with or without tingling in the sensory distribution of the root involved. After a time, the back pain disappears. It may not recur until the next "attack," which may be weeks, months, or even years later. The shortest remission in my patients was a week and the longest fifteen years. Those individuals whose occupations required considerable lifting seemed to be prone to herniation.

Early in root compression, there is pain at

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Thesis submitted to the Faculty of the Graduate School of Medicine of the University of Pennsylvania, toward the requirements for the degree of Master of Medical Science for graduate work in Neurosurgery.

the site of compression of the root and the ligamentum flavum. In herniation of the nucleus of the lumbosacral disc, the first sacral root is most often involved. There is pain in the gluteal region, which radiates down the posterior aspect of the thigh to the lateral aspect of the knee, thence along the posterolateral aspect of the leg to the ankle or the heel. Pain is seldom experienced below the ankle and into the foot. When the fourth lumbar disc herniates, the pain follows a similar course to the knee, thence along the anterior part of the leg to the inner aspect of the ankle. Pain from third lumbar disc herniation follows the sciatic distribution and ends somewhere above, at, or just below the knee.

All symptoms, especially pain, are aggravated by coughing, sneezing, straining, lifting or bending, and often by walking. Any maneuver that temporarily increases the spinal fluid pressure causes pain as long as the root is viable. Continued pressure, however, may interfere with the blood supply of the root, causing it to lose its ability to carry pain sensation.

Another symptom or group of symptoms commonly complained of are paresthesias, either hyperesthesia or painful hypesthesia, depending upon the viability of the root or roots involved. As a rule, when the first sacral root is involved, the paresthesias are located in the heel or in the lateral aspect of the foot and the outer two or three toes. Frequently (62.5 per cent), the patient volunteers that the outer half of the sole of the foot feels numb or asleep. When the fifth lumbar root is involved, which most often occurs at the fourth lumbar disc, the patient states that the numbness or tingling is on top of the foot or in the great toe, or both (37.5 per cent).

EXAMINATION OF THE PATIENT

Observation may reveal that movement aggravates the pain. There is often a characteristic gait, whereby the patient walks stiffly or with a limp.

The normal lumbosacral curve is obliterated, from spasm of the paravertebral muscles. These are often prominent. Scoliosis to the side opposite the sciatic pain is frequently associated.

The patient is unable to bend forward and touch his toes. The patient who can do so probably does not have a ruptured disc. Slight forward bending tends to aggravate the scoliosis, when present.

In a partially flexed position, palpation over the spine or, especially, laterally over the interspaces, causes increased pain, which is most pronounced over the interspace wherein the lesion is located. This was true in more than 75 per cent of the cases, as proved at exploration.

Light percussion over the spine is painful. It is more marked at the site of the lesion.

There is more limitation in lateral bending on the side of the lesion, as well as increased pain. Backward bending is also limited and causes an aggravation of pain.

The jugular compression test done while standing causes back pain in 75 per cent of the cases, and in 50 per cent of these causes pain down the sciatic distribution as well. Frequently, the pain radiates all the way to the ankle. Release of jugular compression may also cause pain.[4] Occasionally, the paresthesias are likewise aggravated. During compression of the jugulars, leading questions should not be asked. The patient should volunteer the information in order to have a positive test. In a negative test, the patient will complain only of a choking sensation or fullness in the head and will not mention pain.

The patient is then examined while he is lying on the table with the affected side uppermost. In that position, examination of the interspaces by thumb pressure to the upper side of the midline causes pain in the back, which is often most marked at the site of the lesion. Care should be taken to exert first a light and then a heavier pressure in order to evaluate properly the response. Light pressure causes considerable pain in the so-called functional back, while heavier pressure causes the same response where a lesion is found.

The patient is next examined in the supine position. The Kernig and Lasegue tests are done, first on the normal side and then on the involved side. Dorsiflexion of the foot aggravates the pain. These are positive in 100 per cent of the cases. When the Lasegue sign is strongly positive, the buttock will be elevated from the examining table.

The patient is then examined while lying supine at the end of the table with both legs extending over, using the buttocks as a fulcrum. This causes severe aggravation of pain, which is relieved by supporting the heel on the normal side.[9]

The reflexes are next tested. It is advantageous to test the upper extremities as well as the knee and achilles reflexes for the sake of completeness and comparison. Here, again, the uninvolved side should be tested first. One should test the reflexes that are equivocal in the supine, lateral, sitting and kneeling positions.

When the patellar reflex (L-3-4 roots) is absent, one suspects the possibility of a disc at L-3. When the achilles reflex (S-1-2) is absent, one suspects a disc at L-5. Sometimes, however, S-1-2 roots are involved at L-4 interspace (9.3 per cent).

When involvement of the root has been of short duration or has been minimal, the reflex will be absent on minimal stimuli and present

with vigorous stimuli. This becomes evident on comparison of the normal with the involved side.

The plantar response should be noted to rule out pyramidal tract involvement. When testing this, the patient will often volunteer that there is a numbness or a tingling sensation, as the case may be.

Testing the dermatomes can be informative and accurate if done carefully, using as nearly as possible equal pressure upon the two extremities at symmetrical sites. When this is done carelessly, it may be worthless or even confusing. Here, also, leading questions should not be asked.

In L-5 lesions, the patient often states that the dorsum of the foot is either "dull," "prickly," or abnormal. When S-1 root is involved, sensation is altered on the lateral edge of the foot and half of the sole. This is best elicited by progressing from the dorsum of the foot to either side.

Paresis is a common finding and can be elicited by (1) having the patient walk on his toes to test the posterior or calf muscles supplied by S-1 root, and (2) by having him walk on his heels to test the anterior tibial group (L-5).

Atrophy of the thigh or calf muscles is a common observation in long standing herniations. It is believed that this is due to disuse rather than to root involvement.[4]

ROENTGENOGRAPHIC EXAMINATION

Roentgenograms of the lumbosacral spine should be made on all patients. These serve a dual purpose. The first is to rule out congenital or acquired deformities or bone lesions which can cause symptoms, and the other is to provide additional landmarks in orientation if operation is necessary. Much has been said about narrowing of the involved disc space; this, however, may not be present or, if present, may or may not be significant in establishing the diagnosis. Lateral bending films, on the other hand, often show a lack of narrowing at the site of the herniation. In addition, scoliosis, which one sees on physical examination, is also present in the roentgenograms.

MYELOGRAPHY

Myelography should be reserved for selected cases.[5] One clinic abandoned it in 1942, as misleading. A ruptured disc can cause pain long before myelography would show a lesion. In my opinion, routine myelography is contraindicated and sometimes harmful. In several cases wherein the diagnosis of a disc was suspected but the history, signs and symptoms were inconclusive, myelography showed a defect though exploration was negative. Conversely, when the history, signs and symptoms were suggestive of a lesion, myelograms were negative yet a true herniation was found at operation.

Root irritation with adhesions may be the result of myelography and can cause symptoms as severe as those of the disc lesion itself. This was more true following the use of lipiodol, when not all of the oil could be removed, than it was with pantopaque, which was more easily removed. In addition, there is the disadvantage that the radiopaque substance, which cannot always be completely removed, may be considered by law as a foreign body and thus compensable.

My experience with oxygen myelography, though limited, has been fairly satisfactory. Its chief objection is that considerable skill is required in developing the technique of taking pictures. This can be attained only through experience.

LABORATORY

Of the laboratory studies, the estimation of the total protein content of the spinal fluid is the most useful. The protein may or may not be elevated and depends upon the amount of obstruction to the spinal fluid circulation, as well as the level at which the fluid is removed in relation to the disc. At, just above, or below the lesion will give a higher reading.

In this group, the protein determinations ranged from 39 to 73.5. In our laboratory, 30 was considered normal.

DIFFERENTIAL DIAGNOSIS

Congenital and acquired bony anomalies, such as spina bifida occulta, absent or malformed facets and spondylolisthesis, can be diagnosed by roentgenograms.

Arthritis can be differentiated by roentgenograms and by the sedimentation rate.[3] The pain is usually diffuse and is referred to the hip or thigh. Hip joint disease may also simulate a ruptured disc. In the former, however, the roentgenograms and Patrick's test are positive, whereas they are negative in a disc lesion.

Primary tumors of the cord and nerve roots, as well as metastatic tumors from the rectum, prostate and pelvis, should be considered. The patient with a metastatic tumor usually gives an antecedent history. There is also a history of bladder and bowel involvement, generally associated with saddle anesthesia. The pain is aggravated by rest and relieved by exercise, which is the opposite of pain from a herniated disc.[2] There is also more paresis and atrophy associated with tumors. Roentgenograms of the spine may show erosion of the pedicles or enlargement of the foramina. The Queckenstedt test is positive and the spinal fluid protein is usually over 100 mg. per 100 cc. If there is a complete block, a Froin syndrome will be present. A partial or complete block will also be demonstrable on myelography.

Tumors of the peripheral nerves may cause

symptoms simulating disc. They may be elicited by palpation along the course of the nerve.

A central massive herniation may give typical cord tumor signs and may not be diagnosed until operation. In this case, sufficiently wide exposure with either hemi- or complete laminectomy is planned before the operation.

Syphilis may simulate disc, but will usually be discovered on routine blood and spinal fluid serology.

If there is an abscess in the spinal canal the patient will usually give a history of previous infection and there will be an alteration in the cell count of the spinal fluid.

Injury can be differentiated by the history or roentgenographic examination, or both.

Hypertrophy of the ligamentum flavum is frequently associated with a protruded or herniated disc.

Polyneuritis is accompanied by evidence of generalized avitaminosis, with skin manifestations. It is relieved when the underlying deficiency is corrected.

A neurofibroma can sometimes be diagnosed by the roentgenogram and by a radicular type of pain which is aggravated by rest.

SUMMARY

The diagnosis of herniated intervertebral disc (nucleus pulposus) can be made correctly by a careful history and physical examination, roentgenograms and laboratory studies in 98 per cent of cases.

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Lumbar Sympathectomy

Increasing interest has been shown in recent years in measures producing increased arterial circulation in the extremities by interruption of the sympathetic nerve pathways. In the lower extremity the most effective and permanent method of producing vasodilatation and increasing blood flow is lumbar sympathectomy. At one time arterial sympathectomy was thought to be an adequate procedure but for the most part it has been abandoned because of the fact that the sympathetic denervation following its use is incomplete and of relatively short duration.—Charles D. Hershey, M. D., Wheeling; W. Va. Medical Journal, Vol. 45, No. 3, March, 1949.

Keeping Up With Medicine

● THEY say that the residual lesions in the lungs from coccidioidomycosis resemble those of tuberculosis in a striking manner.

* * *

● THE value of vitamin E in the management of coronary artery disease is totally unsettled. All reports and comments to date both for and against are unscientific. Livestock men have convincing experiments that the natural vitamin as secured in the diet is essential for the integrity of muscle—especially heart and uterus muscle under the strain of calving.

* * *

● RHEUMATIC fever, which causes about one-third of heart disease, is primarily a disease of children and is responsible for five times as many deaths as infantile paralysis, whooping cough, diphtheria, scarlet fever, epidemic meningitis, or measles combined. It has its ultimate cause in bad housing and inadequate diets.

* * *

● THE incidence of cancer in all parts of the pancreas is about 2 per cent.

* * *

● DEFICIENCY in calcium in the water and soils of a country does not reduce the calcium content of milk from cows living on such soils. It may, however, cut down both the volume of milk persistence of lactation and fecundity of such animals.

* * *

● HYPERTENSION is not a disease per se, but a physical sign, often without, as well as with, accompanying symptoms.

* * *

● IN the management of subacute bacterial endocarditis, the corrent identity of the organism and its sensitivity to penicillin must be known in order to determine the dosage of penicillin.

* * *

● URETERAL injuries are rarely incurred during the performance of pelvic surgery. The incidence, however, is estimated as high as 3 per cent.

* * *

● DURING the past ten years a rapidly increasing number of cases of rat-bite fever have been reported in the United States. Penicillin has proven helpful in one case, others resorted to streptomycin.

* * *

● FEBRILE Herxheimer's reactions are being observed in as high as one-third of a series of patients with neurosyphilis treated with penicillin. —J. F.

Objective Findings in Psychosomatic Dysfunction

CARROLL deCOURCY, M. D., and JAMES E. VOLLMER, M. D.

THE term neurasthenia covers an ill-defined group of symptoms, anxiety neurosis so common today in otherwise mentally normal individuals the cause of which the patient is unable to explain, psychasthenia and psychoneurosis are today coming under the heading of psychosomatic dysfunction. We have classified these cases as a visceral disorder, a symptom complex characterized by instability of the parasympathetic system and electrolytic alterations.

It is evident that the economic crisis through which we are passing in the period between World War I and the present has increased the number of cases. Before this, individuals who had only nervous symptoms now have symptoms definitely neurasthenic in character. The men seem to predominate—students headed for an uncertain goal, repression of any character, individuals in responsible positions, also the laborer in apparently perfect physical condition and great muscular strength. There is an increasing number of patients in whom no definite bodily disease could be found to account for the illness. Dissatisfied with the diagnosis of neurasthenia based only upon the numerous subjective symptoms, we have tried for many years to work out a symptomatology which would give the physician an objective in confirmation of his diagnosis and bring about clearness to this complex subject. Our attention was drawn to certain findings, common to all neurasthenics, slow sedimentation of the blood, increased viscosity of serum, increased red blood count, phosphaturia and hyperacidity of stomach.

SEDIMENTATION RATE

John Hunter in 1797 is given credit for observing that the speed of sedimentation of the erythrocytes was increased in individuals suffering with inflammatory lesions and that this speed varied with the severity of the infection. Interest in this phenomenon lapsed until Fahraeus in 1917 noted it and Linzenmeier in 1920 worked out a technic. Unduly rapid sedimentation might be called "suspension instability" according to Fahraeus. Expressed in other terms it has been claimed to be an accumulation of albuminous decomposition products in plasma which upsets the balance. Expressed in terms of electrical charge, the negative charge of the erythrocytes is neutralized increasingly through absorption of their surface of dispersed albuminous particles; the discharged erythrocytes accumulate in the form of rouleaux and sink more rapidly the larger the rouleaux. The hydrogen ion concentration also influences the results, since acidosis causes reduction and alkalosis acceleration. It was noted that corpuscles of high specific gravity sink more rapidly in normal serum, and normal corpuscles will settle more rapidly in a plasma of low specific gravity. Lowered viscosity of the plasma will increase the rate of settling.

We used in our series the Westergren Method (so well-known today that it is not necessary to describe the technic). We found that the normal readings in men after one hour were 3 to 9 m. m., and in women 5 to 10 m. m.

Up to the present not much attention has been given to slow sedimentation rates. There is no doubt that the phenomenon of sedimentation is caused by a change taking place in the red blood corpuscles, eliminating their ability to circulate separately as single particles in the blood stream. It is evident that the phenomenon of sedimentation is caused by a change in the electrical charge of the red blood corpuscles. If we assume that the loss of electrical charge causes the fast sedimentation, then the red blood corpuscles would be negatively charged. When fully charged they repel each other and circulate as separate bodies. When they lose this charge they cling together in the form of rouleaux. Evidently this hastens the speed to the area of the body where they receive their negative recharge (spleen and liver). If we assume that the loss of electrical charge causes the fast sedimentation we believe we are justified in the presumption that a relatively overcharge of the red blood corpuscles is responsible for the slow sedimentation. We have noted a high specific gravity of the serum in the type of cases in which we find slow sedimentation, the viscosity of the plasma also increased. The

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hydrogen ion concentration also influences the result, since acidosis causes reduction in the rate and alkalosis acceleration.

HIGH RED BLOOD COUNT

It has been noted in these cases a relatively high red blood count is usually found, many times the smaller size of the cells have been noted.

PHOSPHATURIA

That a change in the salt content of the blood serum takes place can be proved by the fact that these patients excrete a great amount of phosphates in the urine. The secretion of the stomach is increased, the acid content very high, and function diminished.

INCREASED IRRITABILITY

There is an increase in irritability of all reflex centers, the sympathetic nervous system being changed in character so that it does not perform its proper function. It is possible under this category to isolate those patients where vasomotor regulation is disturbed. It is possible that the increased electrical charge of the red blood corpuscles or a change in the ionization of the blood causes a similar change in the central nervous system. Disturbance in function may occur in any organ in relation to the hereditary factory in which there is a tendency for one system to predominate.

HYPERACIDITY

That these functional disorders may change to an organic disease is recognized if the vasoconstrictions persist. In gastric neurosis with the hyperacidity, increased peristalsis, and very often muscular spastic contractions, an ulcer may form as a result of a vasomotor contraction of a blood vessel in the wall of the stomach.

Similar conditions may occur in the heart, when we realize how the sympathetic nervous system influences the action and what little control we have at our means to increase or decrease the rate of the heart. The nutrition of the heart muscle is dependent on the condition of the vegetative nervous system. Spastic contraction of the arteries can, therefore, injure the heart muscles. Vasomotor angina pectoris is found often and can be differentiated from the angina caused by arterio-sclerosis by the sedimentation rate. We have invariably found a slow sedimentation in the vasomotor type, but if the spastic contraction lasts over a certain length of time, the muscle degeneration will change the sedimentation rate.

Circulatory disturbances in the central nervous system, spastic circulatory disturbance in the brain resembling a form of apoplexy, these cases as well as certain forms of bronchial asthma, migraine, perhaps certain types of epilepsy and other diseases where no organic change is found, belong to this group. There is no doubt organic changes of the blood vessels of any kind (for example, arterio-sclerosis) cause similar symptoms. We have in sedimentation a method that is a valuable differential point.

As previously stated we found parallel with the increased charge of the red blood corpuscles an increase response of the reflexes, the nervous element was sometimes emphasized so strongly that cases, especially if there existed a tachycardia, gave the impression of hyperthyroidism, the basal metabolic rate however would be in normal limits. The sedimentation rate here is a real diagnostic point in separating psychosomatic dysfunction from true hyperthyroidism. In toxic adenoma of the thyroid and hyperthyroidism, the sedimentation rate is always fast. It is not uncommon for the neurasthenic patient with enlarged thyroid and many nervous symptoms to be operated and find that the fast recovery which is so characteristic to the toxic adenoma does not occur.

Red blood counts of 5,000,000 up to 5,500,000 are frequent findings but patients above 6,000,000 were infrequent, in these cases there is no difficulty in ruling out erythrocytemia, the viscosity never reached the high values associated with true erythrocytemia, also the symptomology was different. In the past we have had the opportunity to study the sedimentation of erythrocytemia and found readings of 0.

In our study we selected male patients of every age. That does not mean that we could not find a similar complex of symptoms in our female patients, but in the female the sedimentation rate is more or less influenced by the menstruation, pregnancy and lactation, so that you seldom find the low figures that occur in the male. Before we accept a diagnosis of psychosomatic dysfunction as final on account of the nervous symptoms and the above-mentioned objective findings, we rule out every other possible cause with the aid of laboratory and X-ray.

CONCLUSION

Of the etiology of psychosomatic dysfunction we know very little, but from observation we are justified in the conclusion that there must exist an hereditary condition on which basis a symptom complex of this type is able to develop, following trauma, a disappointment, a dissatisfaction of some type. To help these patients psychotherapy alone is not sufficient, effort should be made to change the electrolytic reaction in the blood stream. There is no doubt that certain emotions in the subconscious mind can be eliminated by suggestion, and new hope established, but we have found that they are not lasting unless the underlying physiological changes are relieved.

Mesenteric Commune: Report of a Case

JOSEPH L. BILTON, M.D.

IN order to better understand this anomaly of the colon a brief resumé of the embryological changes here follows. The alimentary tract is originally a straight tube from which a portion becomes differentiated as the future stomach. The portion below this continues to grow in length becoming larger than the body cavity. A differentiation into small and large intestine occurs including the development of a cecal bud, the distal portion of which becomes the appendix while the proximal portion forms the cecum. Beyond this is the portion from which is formed the ascending, transverse colon and subsequently the splenic flexure, descending, sigmoid colon and rectum. From then on there is a gradual rotation of the cecum over toward the right side in the upper quadrant and then a descent until it occupies the right lower quadrant.[1]

Tracing this migration then one finds that the cecum begins approximately in the fourth month of fetal life from its position in the left lower quadrant to a position it normally occupies in the right lower quadrant. Coincident with this transposition is a rotation of the small intestine to the left. With this rotation we have, of course, various degrees of failure of rotation. Both incomplete descent and complete failure of descent of the cecum have been described. The clinical importance of this in disease of the appendix is obvious. Failure of rotation of the colon may be associated with a free mesentery for the cecum and ascending colon, a condition known as mesenteric commune. Altschul[2] described two such cases and collected twenty-three others in which the diagnosis had been made either at autopsy or at operation.

CASE REPORT

A white female, Mrs. E. M., aged 59, was admitted to the hospital on May 6, 1947, complaining of pain in the abdomen. Her history began three months prior to her admission with pain in the abdomen of a dull crampy nature which moved about from side to side, was associated with nausea and occasional vomiting. The temperature ranged from 97 to 102. She had ten to fifteen bowel movements a day. Three days prior to admission she became constipated, distended, with recurrent bouts of vomiting.

Heredity: Father and one sister died of diabetes. Family history otherwise negative.

Personal History: Patient has had no operations or accidents. She has been a known diabetic for the past twelve years, controlled by twenty-five units of protamine zinc insulin. Otherwise the history reveals nothing of significance. Physical examination on admission revealed a moderately dehydrated obese white female approximately sixty years of age with no evidence of jaundice, dyspnea, cyanosis or edema. The abdomen was moderately distended. There was tenderness over the entire abdomen, most marked in the right lower quadrant where there was a questionable feeling of fullness, probably due to muscle spasm. Peristalsis was present but diminished. There was rebound tenderness in the right lower quadrant. Temperature was 99.4, pulse 100, respirations 20 per minute. Physical examination was otherwise negative. Impression on admission was that this was a partial bowel obstruction due probably to appendiceal abscess, inflammatory neoplasm or volvulus, in that order.

Submitted June 28, 1948.

The Author

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COURSE AND DISCUSSION

In retrospect, an interesting feature of this case was that she insisted her pain and tenderness, i. e., her whole symptom complex, moved from one side to another. Because she was somewhat psychoneurotic this perhaps was not regarded as seriously as it might otherwise have been. However, her complete work-up revealed the following results: Gastro-intestinal Series: "Stomach revealed slight irregularity of the duodenal bulb with two-hour retention, indicating the presence of a duodenal ulcer on the posterior wall. The small intestinal pattern was normal at the end of three hours." Colon: "Fluoroscopic and film study made before and after evacuation of a barium enema reveal extreme redundancy and elongation of the sigmoid colon. The descending colon appears to be displaced to the right. The barium passes in a reverse manner through the transverse colon and the cecum is situated in the upper left quadrant. This represents what is referred to as a mesenteric commune. No filling defect or other ulceration is seen. Conclusion: Mesentery commune with marked redundancy of the entire colon." See Figures 1 and 2 (next page).

Electrocardiogram revealed moderate myocardial damage with no specific pattern. Sedimentation rate persisted daily at 65 mm. in an hour. Repeated blood cultures were negative. Repeated stools for ova and parasites were negative. However, cultures were positive for B typhus. Widal was positive 1:320 for typhoid, negative for para A and B. She was slightly anemic and sugar was controlled between 150

and 200 mg. per 100 cc. Kline was negative. Urine repeatedly showed many white blood cells. In due time the urinary infection cleared, she improved, became free of her typhoid and was sent home.

DISCUSSION

In addition to the above described anomaly this case is of interest in that a medical condition was responsible for symptoms simulating an acute abdomen. It is of further interest in that her symptom complex shifted from one side of the abdomen to another causing one to view her complaints with suspicion. It is obvious that displacements and malformations of the intestinal tract may have great diagnostic interest and present problems complicating operating technique usually to the embarrassment of the surgeon.

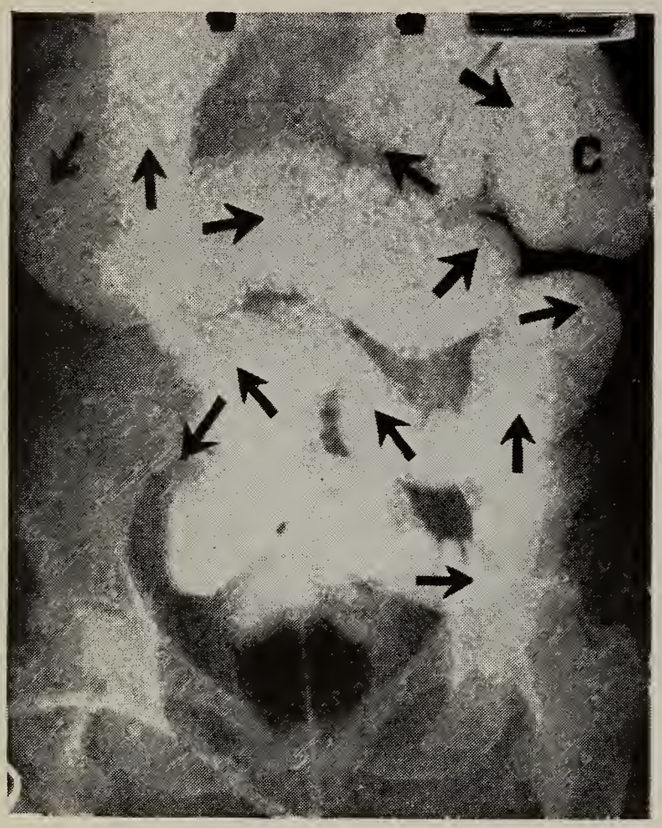


Figure 1. Shows barium filled colon. The line of arrows indicate its continuity. "C" indicates cecum.



Figure 2. Shows emptying film of colon, the arrows again indicating the continuity.

ADDENDUM

Since submitting this paper the author has had the pleasure of seeing two additional cases of mesenteric commune associated with surgical pathology. One, his own, in which the cecum was located between the dome of the diaphragm and liver. This white 63-year-old male had a gangrenous, ruptured appendix with diffuse peritonitis.

Another case, was observed, in a middle aged white male in whom there was an incarceration of the cecum in the left upper quadrant between adhesive bands causing a bowel obstruction.

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Sulfonamide Toxicity

Generalized Hypersensitive Manifestations: These usually occur after six or more days of therapy unless the patient has been sensitized previously by a course of sulfonamide treatment. Drug fever is one of the frequently encountered hypersensitive manifestations, and the differential diagnosis between a drug fever and a fever due to exacerbation of the infectious process being treated may at times be difficult. Keefer and co-workers have offered these points which might aid the physician in diagnosing febrile reactions to sulfa: (1) The onset is usually abrupt and unexplained; (2) The fever is high and intermittent; (3) It usually occurs after one or more days of afebrility when the disease is in a quiescent state; (4) The patient may not appear as ill as the height of the fever suggests him to be; (5) The febrile episode is usually not accompanied by symptoms of the original illness, but by other signs of a hypersensitive state; (6) Onset is most commonly about the seventh day of sulfonamide therapy but may occur as early as the fourth day; (7) Accompanying chills are usually present; (8) There is usually a relative bradycardia; (9) There is rapid defervescence upon discontinuance of the drug. The leukocyte count may be high, low or normal and is of little value as a diagnostic sign.—Jack M. Lynn, M. D., Marysville; California Medicine, Vol. 70, No. 1, January, 1949.

Ovarian Pregnancy: A Case Report

JOHN P. BOLTON, M. D.

OVARIAN pregnancy has received the attention of gynecologists for the past three centuries but its apparent rarity has delayed, until recent years the establishment of definite criteria for its diagnosis. The literature therefore includes many cases of considerable interest which must be excluded as not being of truly ovarian implantation. Considering the few authentic cases reported it seems appropriate to record an additional case in which complete historical and physical findings are available, and in which the diagnosis was established by histological sections of the involved ovary.

REVIEW OF THE LITERATURE

O. Spiegelberg, in 1878 in the *Archives of Gynecology*, published the work which has been largely responsible for the establishment of four postulates for the diagnosis of ovarian pregnancy as follows: (1) The tube on the affected side must be intact and separate from the ovary, (2) the fetal sac must occupy the position of the ovary, (3) the pregnancy must be connected to the uterus by the ovarian ligament, and (4) definite ovarian tissue must be found in the sac wall.

Webster, professor of obstetrics at Edinburgh, in the *American Journal of Obstetrics* stated that Mercerus first described a right ovarian extrauterine pregnancy in 1614 as recorded in *Anthropographia et Osteologia* in Paris in 1626.

Most authors, however, credit Dr. de S. Maurice with reporting the first case of ovarian pregnancy in 1682 in a communication to the Abbe de la Roque.

Catherine van Tussenbroek, writing in the *Annals of Gynecology and Obstetrics* in 1899, described for the first time the histological evidence to clarify and prove the possibility of ovarian pregnancy. She stated that primary ovarian pregnancy is the result of fecundation of an ovum while it is still confined within the graafian follicle.

M. Caturani discussed the relationship of periovaritis and disease of the granulosa cells as cause of primary ovarian pregnancy in the *American Journal of Obstetrics* in 1914 and in 1919.

J. W. Bovee elaborated upon the conflict of clinical and microscopical evidence in the diagnosis of ovarian pregnancy in the *Amercan Journal of Obstetrics* in 1918.

A. Stux classified ovarian pregnancies as intrafollicular, superficial, interstitial, and suprafollicular in 1931.

Submitted June 15, 1948.

The Author

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A. H. Curtis reported approximately 60 authentic cases of ovarian pregnancy. He postulated the need of endometrium for implantation and fecundation within the ruptured follicle.

Thomas, in 1943, set authoritative cases at 65.

Stanley Way reviewed the literature very thoroughly, elaborated upon Cullen's sign and Hoffstatter's modification, and found only 52 cases of true ovarian pregnancy.

Emil Novak, in the last issue of his textbook of pathology, is willing to concede only about 50.

R. Glen Craig of Leland Stanford University Medical School, who has recently covered the subject adequately, believes that not over 70 cases of undoubted instances of ovarian origin of pregnancy have been reported.

CASE REPORT

Mrs. D. T., aged 20, entered White Cross Hospital, Columbus, Ohio, November 3, 1947, at 2:15 p. m. History revealed that on September 18, 1947, her last normal menstrual period started, lasting five days. This menstrual period was associated with slightly more than her average amount of dysmenorrhea. There was slight nausea and anorexia, and headache, frontal in type, was slightly more pronounced than usual. There were noted some liquid stools. There was dizziness and spots before the eyes, especially when looking up suddenly. Nervousness was more pronounced, perspiration was somewhat excessive at times, and the hands were cold and slightly clammy. These symptoms persisted after the cessation of the menstruation, and there was a faintness which had not been observed following any previous menses. These symptoms became gradually worse the second week of the cycle, at which time the patient lost two days of work. On October 16, she noted some pain before onset of the next menstrual period, which was unlike menstrual cramps, and slightly toward the right side. This menstrual period, lasting four days, was very scant, then stopped one day, and recurred every other day upon exertion.

On November 2, while sitting on the davenport after dinner, she suddenly was seized by a sharp pain low in the right side, which gradually became worse and felt like "three separate pains with one shooting into the left side, and one up the middle." She went into the bathroom and tried to move her bowels, urination at this time being very painful. She came back downstairs where the pain eased slightly upon resting, then started again in a few minutes. It was

obvious to the patient that the abdomen was swelling and becoming tense. When she fainted, a doctor was called who, when unable to obtain a hospital bed, administered a hypodermic. Vomiting occurred intermittently through the night.

The past history was entirely negative except for an appendectomy February 3, 1946. The operation was an interval appendectomy, the pathological report was chronic appendicitis, the pelvic organs were normal, and the convalescence was rapid and uneventful.

Examination was first made at the office about 10:00 a. m., on November 3, 1947, about fourteen hours after the onset of severe pain. The blood pressure was 98/64, the weight 115, the heart rate 100, and the temperature 99.6. The entire abdomen presented abnormal sensitivity, but tenderness was most pronounced in the lower abdomen slightly toward the right side. There was only slight rigidity, but the abnormal fullness of the abdomen was apparent, and imparted to it a tense and doughy feel. Upon pelvic examination the cervix was found to be normal in size and appearance, except that there was extruding from the external os a blood tinged non-purulent mucus. The uterus was found to be slightly enlarged, and there was extreme tenderness in the lower abdomen, particularly in the cul-de-sac toward the right side, where there was a full, doughy feel upon bimanual palpation. The tentative diagnosis was a right ectopic pregnancy, ruptured, with profuse intra-abdominal hemorrhage. A blood count was ordered which revealed blood loss as follows: Hemoglobin 9.9 grams, erythrocytes 3,330,000, achromia slight, anisocytosis slight, poikilocytosis slight, leucocytes 15,300, neutrophiles 82, lymphocytes 18.

A hypodermic was administered at the office to purposely reduce blood pressure and thus minimize intra-abdominal hemorrhage while awaiting a hospital bed.

Admission to the hospital was gained at 2:15 p. m. and laparotomy was promptly performed. There apparently was little failure in the patient's general condition in the hours of waiting due to sedation and quiet. Five per cent glucose in saline and plasma were begun in the operating room. The preoperative diagnosis was an ectopic pregnancy, right, tubal, ruptured. The postoperative diagnosis was an ectopic pregnancy, right, ovarian, ruptured. The operation was oophorectomy, right.

PROCEDURE

A lower midline incision was made and an abdominal exploratory was begun. About 500 cc. of sanguinous fluid with withdrawn from the abdominal cavity by suction, and a large emesis basin full of blood clots was removed by hand. The right ovary was found to be the site of the hemorrhage. The pelvic organs were then carefully examined. The left tube and ovary were found to be entirely intact, separate, in normal position, and showed no signs of pathology except for the slight irritation of free blood in the peritoneal cavity. On the right side the tube was found to occupy normal position, be normal in size, its fimbriated end was free, the caliber of the tube was normal throughout, and there were no signs of injury to its peritoneal surface or inflammation. Upon lifting the right ovary, however, which was free from the tube, it was found to be about twice normal in size, enlarged by a cystic structure with black contents, which presented on its inferior surface a large black crater about 3 cms. in diameter, with several bleeding points obviously the source of the intra-abdominal hemorrhage. The right mesovarium was clamped and severed between clamps. Chromic No. 1 catgut suture ligature was used to replace the clamps. A like suture was used for running closure of the peritoneum and fascia separately. Plain 00 catgut was used for intradermal approximation of the skin.

FINDINGS

The patient was about one-third exsanguinated by intra-abdominal hemorrhage. The abdomen contained about 500 cc. of sanguinous fluid and a large amount of blood clot. The right ovary

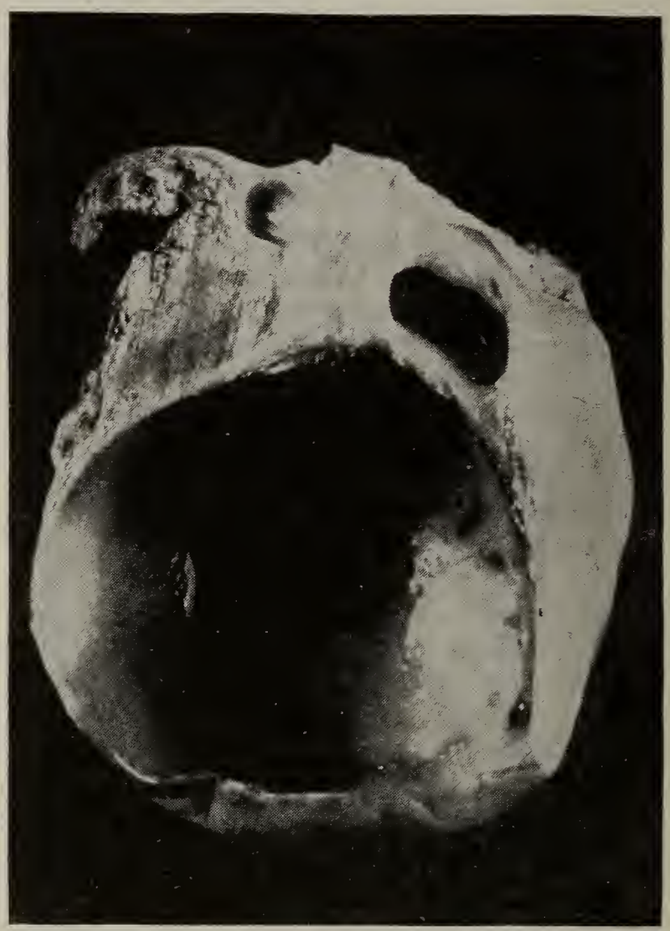


Figure 1. Gross ovary showing remaining luteal follicle on surface, which follicle contains the pregnancy implantation.

was about 6 cms. in diameter and contained a cystic structure which appeared to contain dark blood or placenta through a thin membrane. On the inferior surface of this ovary was a bleeding crater, out of which there apparently had been extruded the products of early pregnancy. A thin serous sac was noted in the clotted blood contents, which were removed from the abdominal cavity. This along with the clotted blood and right ovary were sent to the laboratory for study. Transfusions were in readiness for blood replacement.

The postoperative course was uneventful. Three transfusions of 500 cc. of whole blood, each with 500 cc. of normal saline, were used on successive days in addition to other fluids required to restore blood loss and maintain normal fluid balance.

PATHOLOGY

"The specimen consists of one ovary, a cystic sac like structure, and of a large mass of recent blood clot. The ovary measures 4 x 3-1/2 x 3

cms., and presents on the surface an area of hemorrhagic extrusion measuring 20 mm. in diameter. The remainder of the ovarian surface is smooth and the ovary is apparently cystic. The hilus of the ovary shows no enlarged or bleeding vessels and on cut section the ovary is found largely replaced by a serous cyst, measuring 2-1/2 cms. in diameter and filled with a blood tinged coagulum. Adjacent to this is approximately one-half of a recent corpus luteum showing some hemorrhage and a central white coagulum and this remainder of the luteal follicle is apparently the source of hemorrhage. A few follicle cysts remain within the ovarian stroma near the hilus (Figure 1). The sac measures approximately 12 cms. in diameter, and shows no apparent tissue components or products of pregnancy.

MICROSCOPIC

"Sections of the ovary through the area of bleeding show the ovarian tissue itself to be oedematous, and there is a deeply placed corpus luteum formed of well developed luteal cells.

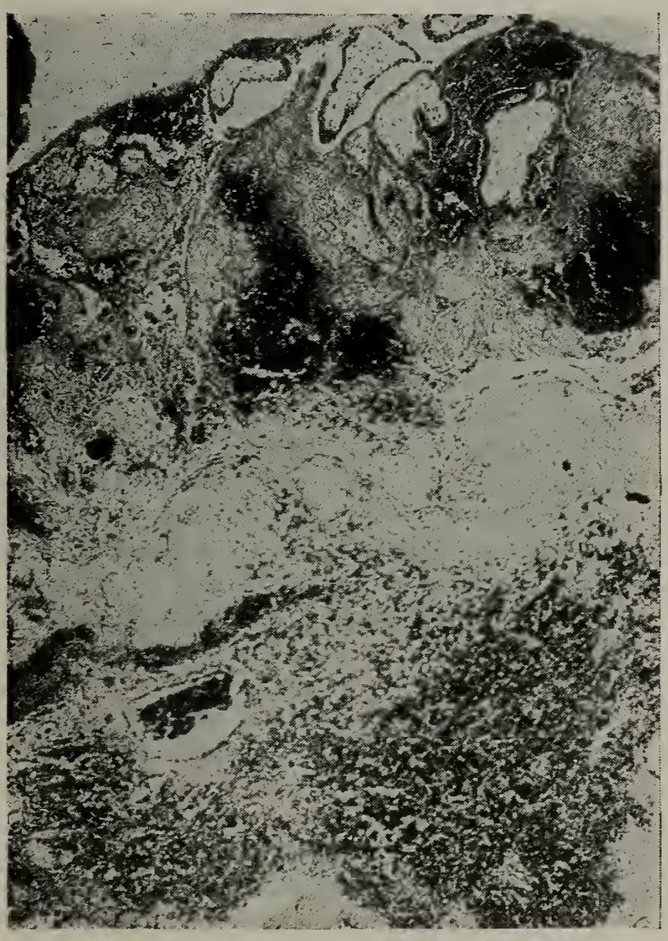


Figure 2. Microscopical section of the luteal follicle pregnancy showing chorionic villi on the surface, a zone of hemorrhage and syncytial cells, and a deep layer of partially destroyed luteal cells.

External to this corpus luteum is a mass of hemorrhagic material continuous to the ruptured surface of the ovary, and infiltrating this hemorrhagic material are syncytial cells extending downward to the ovarian tissue; and also within the hemorrhagic material of the ovary there are multiple young chorionic villi (Figure 2). Sections of the large mass of blood clot show no further products of pregnancy. Sections of the separate clot show no further products of pregnancy. Sections of the separate sac show it to be a simple peritoneal cyst and not a trophoblastic vesicle. Diagnosis: Ovarian pregnancy with massive hemorrhage."

The patient was released from the hospital November 12, 1947, and upon postoperative checkup at the office on November 24, was found to have no complaints and showed good progress. The blood pressure was 114/86, temperature normal, and weight 111 lbs. as compared to 115 on the day of surgery.

DISCUSSION

Ovarian pregnancy has no preoperative differential diagnosis. It is unthought of until the gross findings at surgery suggest it. Hence, the early symptoms of ovarian pregnancy are those common to the early tubal pregnancy, that is, amenorrhea, nausea, vomiting, frequency, soreness of breasts, and vague discomfort in the affected side. Vaginal examination may show slight softening of the cervix, slight enlargement of the uterus, and a slight sensation of a mass in the affected side. Few women see a physician at this time; consequently few ectopic pregnancies are diagnosed on the early findings.

When rupture of an ectopic pregnancy does occur however, an extremely accurate history is imperative if a correct diagnosis is to be made. There is a period of amenorrhea of one month or longer, usually about six weeks. There is generally spotting and bleeding, clotted or dark, intermixed with a clear mucus extruding from the cervix. The pain in the pelvis is sudden, severe, or lancinating; it starts frequently in the bathroom or where there is some other effort causing increased intra-abdominal pressure. The abdomen fills, distends; there ensues faintness, weakness, shock, which often recovers temporarily, then recurs when the patient resumes activity. Cullen's sign is seen only in a certain type of umbilicus, and then only usually late, or when cases are not diagnosed early. The urine becomes scant, and there may be hemoglobinuria. Thirst, accordingly, becomes excessive, degree dependent upon the amount of fluid loss. Implantations other than in the uterus may be ovarian, tubal, cervical, or abdominal. The tubal pregnancies may be further sub-divided into ampullary, isthmal, and interstitial.

The eventual termination of any of these implantations presents several possibilities. First, there may occur an early death of the fertilized ovum with resorption; secondly, development to an advanced state may occur with even the possibility of delivery at term by laparotomy. If retained however, death of the fetus may be followed by suppuration, skeletonization, saponification, and even lithopedion; thirdly, rupture may occur at any point along the progress of development, and the fetus may die or become reimplanted and continue to grow. The placental attachments may occur at the primary sites and the fetus, though its position is changed, con-

tinue to develop. This presupposes that the rupture with its associated hemorrhage into the peritoneal cavity, ignored or misdiagnosed as it may be, does not produce sufficient exsanguination of the patient to prevent further change and development of the fetus.

Every case diagnosed should go to surgery promptly regardless of condition. If condition is critical due to blood loss, the patient should be bolstered on the way to the operating room. The only delay justifiable is the few minutes required in the operating room to start such treatment agents as plasma, glucose, or whole blood. Good anesthesia is very essential. There can be no such thing as expectant treatment. The prognosis is more serious the longer delayed. There will follow marked improvement in the pulse and the patient's condition in general as soon as the bleeding vessel is ligated. The most advantageous time for fluids and stimulants is during or after the control of hemorrhage by ligature. All clotted blood should be removed, and the surgery should be minimal. The surgeon who also removes the appendix, suspends the uterus, or explores needlessly is meddlesome, and invites morbidity, if not mortality.

SUMMARY

1. A review of the literature establishes ovarian pregnancy as a rare condition.
2. The criteria for its diagnosis is presented.
3. An additional case is reported.

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Juvenile Diabetes

There are living today in the United States a group of diabetics, in whom the onset of diabetes occurred before the fifteenth birthday. This group numbers approximately 50,000 individuals. These juvenile diabetics show a high incidence of premature vascular disease.

Vascular damage in this group commonly appears long before the age at which it is usually observed in the average individual. Although it may appear prematurely in diabetics who experience onset after reaching adult life, many such individuals, when vascular damage becomes evident, have arrived at the time of life when arterial disease is frequently seen, regardless of diabetes, in contrast to the still young age of the juvenile group.

This vascular damage in the juvenile group commonly becomes evident first in the retina. The next most common evidence arises in the kidney. The heart, brain and general vascular tree also present degenerative manifestations.

The nature of these degenerative vascular lesions remains almost entirely controversial. There are those who claim that they are the direct result of diabetes, especially when poorly controlled. Among diabetics with onset in adult life, any natural constitutional or hereditary tendency to premature vascular age could possibly be aggravated by the occurrence of diabetes but this factor would not likely be operative in the juvenile group. Because atheromatous vascular degeneration is the type of vascular disease which is most characteristically observed in the diabetic, there are those who believe these clinical pictures are the product of a disordered fat metabolism. If one is to believe that premature vascular disease occurs as a direct result of and secondary to especially poorly controlled diabetes, it is difficult to explain the exceptions.

Furthermore, all those, who observe any considerable number of diabetics over a period of time, are at a loss to explain why certain patients, whose records show continuous poor diabetic control in spite of higher doses of insulin, still fail to reveal after fifteen years or more of diabetes and after thorough examination, any evidence of vascular disease inconsistent with age, while other patients, with much milder diabetes of much shorter duration, show extensive damage. These exceptions to the rule would suggest that in some, and perhaps in most but not in all diabetics, there is a metabolic disorder which is not always part and parcel of the primary disease. It is these exceptions which affirm the fact that our knowledge of the metabolic defect in diabetes is far from complete. —R. P. Pillow, M. D., & Lester J. Palmer, M. D., Seattle, Wash.; Northwestern Medicine, Vol. 48, No. 2, February, 1949.

Conservative Irradiation of the Nasopharynx

HARRY H. HAGGART, M.D.

THE wide-spread approval of the use of radium irradiation of the nasopharynx warrants a consideration of its value and a warning as to its use. At the recent meeting of the Academy of Otolaryngology, several radiologists warned of the dangers involved in the use of excessive dosage. It was contended that this might result, years later, in malignant degeneration of tissue thus treated. They showed illustrations of skin malignancies following irradiation. It seems important that clinicians should be able to use radium with assurance that the present good results shall not be followed by such tragedy.

In the first place, its use should be restricted to properly selected cases and secondly, safe dosage should be used.

The most widely used radium applicator was designed by Dr. S. J. Crowe of Johns Hopkins—the 0.3 mm. monel metal instrument for the treatment of hyperplastic lymphoid tissue in the nasopharynx. In this limited field, the results have been most gratifying and more far-reaching than one would expect, for the nasopharynx seems to be a key area. The adenoid tissue lies between the Eustachian orifices, very often completely covering them, not to mention its relationship to the sinuses just above and the lymphatic drainage downward toward the lower respiratory system.

The results in deafness, especially in children, are well known. Even in mixed deafness, with some conduction defect, there has been improvement sufficient to enhance the value of a hearing aid later. Many cases of chronic otitis media have responded, although no promises can be made in this group.

Further, the nasopharynx seems to be the portal of entry for viruses and bacteria, and irradiation seems to block this portal to invading organisms. Its use lessens the incidence of upper respiratory infections, sinus involvement and pharyngitis.

With such gratifying results goes the temptation to use more treatments and greater dosage. Those of us who use radium assume a serious responsibility. We must follow the routine of those who, with physicists, have worked out a safe procedure over a long period of time. The use of the 50 mg. applicator seems to offer a safe routine. It is inserted through the nose and should be used for twelve minutes on each side, not more than three or four times at two-week intervals within the year. If adenoids are large, they should be removed surgically and the operation supplemented with three radium treatments beginning two weeks after operation.

It is advisable in all cases to use a nasopharyngosope to diagnose the presence and extent of the lymphoid tissue and to follow the course of each case during and after treatment.

In a recent personal communication, Dr. Crowe wrote, "The object is to remove nodules of lymphoid tissue in areas inaccessible to operative removal. If a small twelve-minute dosage is used, the lymphoid nodules regress in size, but may recur a year later under the stimulus of upper respiratory infections, just as they may recur after operative removal. If a larger dose is used, the lymphoid tissue may be entirely and permanently removed from the nasopharynx, but in the process other tissues and structures that are perfectly normal are over-irradiated. This is neither necessary nor wise."

Several factors in this potentially dangerous procedure may well be mentioned. First, there are various types of applicators in use, each with different weights of radium and with varying types of filters. A twelve-minute dosage with one might be entirely different with another. Also, patients frequently wander from one physician to another. They should be carefully questioned, for they may have already received either radium or, even more frequently, X-ray irradiation. One needs not mention that careful records should be kept on each case including dates and dosage.

Dr. Crowe has recently written "Irradiation of lymphoid tissue has now been used for twenty-four years, and many thousands of patients have been treated. In all this time not a single instance of burn or other complication due to the use of radium has been observed."

Keeping in mind the sharp warnings of danger by radiologists, we should follow the advice of conservative clinicians of long experience.

Submitted November 18, 1948.

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Essential Dysmenorrhea—Its Pathogenesis and Treatment

LEONARD B. GREENTREE, M. D.

PAIN will occur anywhere in the human body where ischemic muscle contracts. It was Moir[1] in 1936 who first suggested the relationship between the pain of dysmenorrhea and that of intermittent claudication and angina pectoris. In all of these conditions, there is a piling up of the "P" substance of Lewis,[2] until it reaches a certain threshold concentration whereby it stimulates the sensory nerve endings. This "P" substance of Lewis is a degradation chemical product of muscle metabolism. It is increased with muscle activity, and when there is an insufficient amount of blood to carry it away.

Uterine muscle contraction is believed to be under the control of the ovarian hormones, but the manner of control is still under dispute. Knaus, Novak and Reynolds, and Falls believe that estrogen increases uterine contractions and that progestrin nullifies this action. On the other hand, Moir believes that estrogen causes frequent uterine contractions of low amplitude and that progestrin causes slower uterine contractions of a higher and more forceful amplitude.

Normally, the Kieffer sensory corpuscles in the cervix are stimulated by a variable concentration of the "P" factor of Lewis. These sensory impulses are transmitted to the spinal cord through myelinated sensory nerve fibers in the pelvic nerve which also contain efferent parasympathetic nerve fibers. These impulses ascend through the spinal cord to the thalamus in the center of the brain, where they may be interpreted as being pain. This impression of pain then goes to the cerebral cortex for motor response, which takes place through the medium of the pituitary and adrenal glands, causing an increased secretion of adrenalin. This increased adrenalin secretion is nature's defense against danger, by causing vasoconstriction to save blood.

According to Reid, fear is a protective mechanism which is an exaggeration of the alertness to danger, and it is an emotion which is acquired by suggestion or association. Anxiety can cause the thalamus to become hyper-sensitive, so that the pain interpretation of the afferent sensory impulses may be exaggerated. The cerebral cortex receives an impression of pain which increases vasospasm, thus producing more pain and setting up a vicious circle.

Novak and Harnik believe that all cases of essential dysmenorrhea are explained on the basis of pyschic trauma. These authors report 168 cases treated by psychotherapy with an amazing result of complete relief in 71 cases and partial improvement in 89 cases. Davis and Cotte believe that a neuritis of the pre-sacral plexus which normally sends vasoconstrictor sympathetic nerve impulses to the uterus, is an important cause of essential dysmenorrhea. Davis found pre-sacral neuritis to be present in 70 per cent of his patients with essential dysmenorrhea. Hertig,[3] however, states that he has never seen a single neuritis of the pre-sacral plexus in several hundred specimens examined after pre-sacral neurectomies done during the past ten years at the Free Hospital for Women in Brookline, Massachusetts.

Wilson and Kurzrok observed in 1938 that only patients who ovulated can have essential dysmenorrhea. Allbright and Sturgis[4] confirmed these observations in 1940. Ingersoll gives his patients with severe intractable essential dysmenorrhea, a course of estrogens, establishing an anovulatory menstrual cycle. If pain persists with an anovulatory cycle, the patient is then referred to a psychiatrist. If the pain disappears, a pre-sacral neurectomy is done.

In the light of our present knowledge of hormone physiology, the mechanism of essential dysmenorrhea may follow along the following pattern:

A. **Estrogen** is thought to be a vasodilator, a diuretic, and an excretor of sodium chloride from the human body, by:
   1. Being cholinergic, liberating vasodilator parasympathetic acetycholine.
   2. Inhibiting the pituitary gland. Rock believes that small daily doses of estrogen will stimulate the pituitary gland while larger doses, over 500 R. U., will depress this

Presented at Staff Meeting, St. Francis Hospital, Columbus, Ohio, June 21, 1948.

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gland. Decreased activity of the pituitary gland could cause:

a. Decreased secretion of pituitrin, which is anti-diuretic, a vasopressor, and oxytocic.
b. Decreased secretion of the adrenotropic factor by the anterior pituitary gland would lessen adrenal activity, causing:
   (1) Decreased secretion of desoxycorticosterone hormone by the adrenal cortex, with a resultant diuretic action and loss of sodium chloride.
   (2) Decreased secretion of adrenalin, causing a vasodilatation.

B. **Progestrin,** formed after ovulation, tends to nullify this action of estrogen. Thorne believes that progestrin resembles desoxycorticosterone in its electrolytic action. Greenhill and Freed[5] relieved premenstrual tension and edema by giving their patients ammonium chloride and a salt-poor diet. Normally a high plasma level of sodium chloride will stimulate the posterior pituitary gland, causing a retention of fluid to dilute the concentrated extra-cellular fluid. A low plasma level of sodum chloride will inhibit the posterior pituitary gland, causing a diuresis. Ammonium chloride acts by breaking down into urea, a mild duretic, and into chlorine ion which unites with the sodium radical, forming sodium chloride. It is the sodium ion which binds water to the tissues. This sodium chloride is passed through the kidneys with the water liberated from the tissues. McPhail causes a diuresis and loss of sodium radical by giving the patient large amounts of fluids, diluting the extracellular sodium chloride and thus inhibiting the posterior pituitary gland.

Dysmenorrhea is often associated with hypometabolism (hypothyroidism). The mechanism is not clear, but Thompson[6] believes that normally, thyroxin has an inhibitory action on the pituitary gland. Hence in hypometabolism, there is increased pituitary activity, causing an increase in vasospasm and retention of water and sodium chloride.

TREATMENT

The treatment of essential dysmenorrhea, if the foregoing discussion is accepted as being rational, may include the following procedures:

1. A psychiatric consultation if there is a question of anxiety on the part of the patient.
2. A salt-poor diet, ammonium chloride, and forcing of fluids in the latter half of the menstrual cycle.
3. Use of thyroid where hypometabolism is present.
4. Use of choline derivatives which are cholinergic.
5. Use of other vasodilators.
6. Use of estrogens to establish an anovulatory menstrual cycle.
7. Prolonged dilatation of the cervix, causing a temporary overstretching of the sensory corpuscles of Kieffer. Parturition may destroy the Kieffer sensory corpuscles permanently, so that essential dysmenorrhea frequently disappears following parturition.
8. Pre-sacral neurectomy which acts by interrupting the flow of sympathetic vasoconstrictor impulses to the uterus. Tucker reports 89 per cent complete or partial relief in 119 cases of essential dysmenorrhea where a pre-sacral neurectomy was done. Duncan[7] states that surgical intervention should be considered in any girl totally incapcitated for twenty-four hours or longer, when this difficulty has continued for a year or more. Surgery is often a practical method of dealing with persistent intractable cases where the economy of the patient would not permit prolonged medical treatment.

SUMMARY

A discussion of the hormonal mechanism of essential dysmenorrhea is presented, along with an outlined physiological treatment.

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Dexedrine and Weight Reduction

The effect of Dexedrine on weight reduction was studied in 30 obese individuals. It was found that satisfactory weight reduction (a minimum of 1 pound a week) could be maintained for an average of approximately eight weeks. After that, the weight soon became stabilized at a lower level, and a satisfactory rate of weight reduction could not be maintained on the dosage of Dexedrine used (a maximum of 30 mg. daily). Toxic symptoms were infrequent and mild. No significant change in the blood count, urinalysis, basal metabolic rate, electrocardiogram, glucose tolerance, blood cholesterol, and blood proteins was discernible in nine patients on whom these tests were performed before, during, and after medication.—E. Philip Gelvin, M. D., and Thomas H. McGavack, M. D., New York City; N. Y. State Jrnl. of Medicine, Vol. 49, No. 3, February 1, 1949.

Postoperative Care After Ileostomy

JOHN M. WALKER, M. D.

THE use of an ileostomy to interrupt and divert the fecal stream from its normal course has become a fairly common surgical procedure. It is most commonly used in the disease process of ulcerative colitis and it is with this in mind that I shall discuss the care and handling of the ileostomy patient. However, ileostomy may be used in varied pathological states such as multiple polyposis, cancer of the colon, inflammatory disease of the colon and small intestine, intestinal obstruction, and in tumors of the small bowel. In ulcerative colitis and multiple polyposis, except for the occasional case, the ileostomy is usually of a permanent type, while in the other conditions it is almost always a temporary measure.

For many years both medical men and surgeons have looked upon the creation of a permanent ileostomy almost with horror and one must frankly admit that it is not an ideal surgical procedure; but on the other hand if handled correctly most of these patients do remarkably well and can be returned to a full and active life. Recently I saw 16 patients of Dr. Henry W. Cave in New York, each of whom had had an ileostomy of five years' duration or longer. One could not help but be impressed by the appearance of well-being of this group.

The ulcerative colitis patients represent the most trying type of case as they usually have had the disease for a long period of time with fifteen to thirty stools per day. They almost always show marked weight loss, anemia, protein deficiency, electrolyte imbalance with reduction of the plasma chlorides and various vitamin deficiencies. It should be noted that many of these patients are real problems from a psychosomatic angle. Consequently, in order to manage these patients properly, one must take into account all of the above as well as the usual problems one faces in any intestinal surgery. Let me add a note of warning and that is that the young child or infant does not tolerate an ileostomy well.

FLUID AND ELECTROLYTE BALANCE

Accurate preoperative studies are, of course, essential. Correction of anemia, protein, salt and vitamin deficiencies should be done before surgical intervention to as great an extent as possible and after the ileostomy these must all be watched closely. Fluid balance must be maintained. The clinical appearance of the patient is an important guide as to whether the patient is hydrated or not. There are several tests which are of value and which should be used along with one's clinical judgment in regards to determining the status of water and electrolyte balance. One of the simplest of these is one of the best and that is measurement of the daily urinary output with determination of the urine specific gravity. If the patient is putting out between 1200 and 1500 cc. of urine daily, the intake is usually sufficient. The following blood studies may be of value: Hematocrit, complete blood count with hemoglobin, plasma protein, plasma chloride, blood urea and CO_2 combining power determinations. The latter is especially useful, when there is profuse fluid loss from the ileal stoma, to determine the degree of acidosis present. One should bear in mind, however, that these tests give us simply a picture of one or more factors in the circulating blood and they tell us very little about the state of the intracellular and extracellular fluid. But by using clinical acumen with the above tests, one may intelligently administer fluid therapy.

It should be remembered that when giving large amounts of fluids intravenously there is little danger if the fluids are given slowly and also if there is simple water loss—water and not salt is what the patient requires. For this reason, plasma chloride determinations should be used frequently.

CARE OF THE ILEOSTOMY STOMA

The technic of creating a satisfactory ileal stoma has been described by others. Suffice it is to say the ileum should be well fixed to prevent prolapse or recession into the abdominal cavity and should extend above the skin for a distance of one to two inches, so that it will fit well into an ileostomy bag. The most satisfactory way for handling the ileal discharge

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The Author

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during the immediate postoperative period is to introduce an adequate sized rectal tube well down into the ileum and to fix it securely in place. The rubber tube should be hooked up to a drainage bottle and the ileal discharge will not touch the skin for approximately five days. This is extremely important as the discharge is both bacterially contaminated and highly irritating and one will find, if this is not carried out, a very troublesome wound infection will likely occur. If the tube should stop draining at any time during the early period, and this is fairly common, it should be irrigated gently with warm tap water. This will usually relieve any partial obstruction and clear the tube which may be obstructed with fecal material. At the end of four to five days, it will be necessary to remove the tube and at this time daily dilatation of the ileal stoma with the finger is important. It takes approximately one to two months for the mucous membrane of the protruding ileum to grow down on the outside of the stoma, and, hence, it is necessary to dilate until this occurs. If this is not done the stoma may become constricted by fibrous tissue and obstructive symptoms result. The mucus fistula of the distal ileum requires very little care if it has been properly fixed.

CARE OF THE SKIN

Irritation of the skin is the most frequent and troublesome complication following ileostomy and even with the greatest amount of attention and care, skin irritation will occur. However, the amount of irritation can be definitely lessened and usually controlled. I have found the following regime of value. On the third postoperative day, with the ileal tube still in place and functioning, the skin about the ileum is painted twice daily with tincture of benzoin. After the tube has been removed there is one fundamental rule: Do not let the skin be in contact with the moist fecal material for any prolonged period. The following routine is instituted at the time of removal of the tube.

1. Cleanse skin thoroughly with soap and water followed by alcohol and allow to dry.
2. Paint skin with tincture of benzoin and when dry dust with fuller's earth.
3. Cut a thin rubber sheet with a hole in the middle to fit the ileostomy stoma and drape over abdomen. Adequate gauze fluff dressings should then be placed over the ileostomy stoma on the rubber sheet to take up the liquid stool.
4. Change dressings frequently.
5. Limit fluids after evening meal, so that ileal discharge is not excessive at night when patient is asleep.

The cleansing of the skin should be done daily for the first few weeks. If then the skin is irritated, allow the skin to be in the air as much as possible and keep as dry as possible. During the time I was with Dr. Henry Cave in New York we tried almost every conceivable type of material on the skin, including different ointments, aluminum paint, different rubber preparations, some of which could be painted on the skin, and all types of powders. We found no miracle concoction. However, we did find that as a rule the drier the skin was kept the better the result.

At the end of two to three weeks in some clinics a temporary ileostomy bag is applied and worn for two months, when it is discarded and a permanent bag is then used. I have had no experience with the temporary bag but the idea is sound. So far as the permanent bag is concerned, the Rutzen Bag is the most satisfactory type that I have seen. This bag adheres to the skin and there is no leakage so that skin irritation is well controlled once the bag is applied.

DIET

The ideal type of diet for these patients is a high protein, high caloric diet which is nonirritating in character. It should be started as soon as possible after surgery. Peculiarly-enough, eggs, which are generally thought to be one of the basic foods to which these patients are sensitive, I have found to be tolerated very well. During the first two weeks after the ileostomy the caloric value of the diet should be increased as rapidly as possible so that when these patients are ready for discharge they are taking in the neighborhood of 3000 calories. At times this is difficult. The patient is instructed to watch for foods or beverages that may cause diarrhea, but not to decide too hastily that such a food is responsible. At the end of one to two months, if the stools are becoming formed, fruit juices can be carefully added, so that in a relatively short period of time the patient is taking a full and well-balanced diet.

Most of the patients who require an ileostomy because of ulcerative colitis show evidence of vitamin deficiencies, especially of the B complex group. It is almost a rule for these patients to show evidence of this deficiency in their small intestinal pattern after taking barium by mouth. Vitamins A, D, B_1, B_2,niacinamide and ascorbic acid should be given well above the daily minimum requirements postoperatively. At the end of two to three months all vitamins may be discontinued, with the exception of Vitamin C if fruits and fruit juices are poorly tolerated.

PSYCHOTHERAPY

Almost all patients with ulcerative colitis have a psychoneurosis to a greater or lesser degree. Perhaps some of these patients could be helped in the early stages of their disease by proper psychotherapy. However, by the

time they are seen by the surgeon, there is usually marked organic change of the bowel wall with a severe diarrhea and discharge of blood and mucous as well. In fact, one often wonders if the bowel symptoms are not the cause of the psychoneurosis rather than the result of it. To add an ileostomy as another problem for these patients to handle may seem formidable and yet it is surprising how well they will accept and tolerate their ileostomy with all of its trials and tribulations. Every surgeon should realize, however, that these patients require understanding and encouragement, especially during the first year after ileostomy. The surgeon must be willing to sit down and talk over with them their problems and to give them all the support it is possible to give. He should develop a rapport with the patient that will enable him to guide these patients back to a normal life.

INTESTINAL OBSTRUCTION

Intestinal obstruction, both partial and complete, is common following ileostomy. In fact, it is quite unusual for a patient not to have at least partial obstructive symptoms at some time in his postoperative course. As mentioned previously, finger dilatation of the ileal stoma is necessary during the first two months and also at times it may be necessary to introduce a catheter and irrigate the lower ileal segment. Even at a later date after six months or more have passed, the introduction of a catheter may relieve completely what at first one thought to be an obstruction requiring surgery. Finally, it must be realized that obstruction requiring surgery occurs frequently. The cause is usually a volvulus of the small intestine about the ileum just below the abdominal wall or adhesions constricting the small bowel. In these conditions, it may be necessary to take down the ileal stoma and reconstruct a new opening with or without resection of the intestine.

PROLAPSE OF ILEAL STOMA

This is a frequent occurrence despite the fact that the well-educated surgeon is aware of the danger of it and has done his level best technically, while constructing the ileal stoma, to overcome it. Cave has had a prolapse occur ten years after the original ileostomy. If a real prolapse occurs it is usually necessary to do a resection of the prolapsed portion and to reconstruct the ileostomy. It should be noted that careful fixation of the mesentery of the ileum to the peritoneum is essential to lessen this serious complication.

DIARRHEA

Severe bouts of profuse diarrhea may occur after ileostomy. These are usually due to beverages or foods which the patient cannot tolerate or to emotional upsets. Most of the patients learn in a comparatively short period of time just what they can and cannot eat and drink and when questioned they can usually list four or five foods or a beverage (usually alcoholic) which will immediately cause diarrhea.

A severe diarrhea in a patient with an ileostomy is often of serious import and should be corrected immediately. Due to the fact that large quantities of fluid are lost through the ileostomy with a loss of sodium chloride as well, we have a mixed type of dehydration with both salt and water depletion. The clinical picture is one of shock. The treatment is replacement of water and salt. However, if the dehydration is marked, there is apt to be loss of protein and transfusions may be necessary to correct the protein deficit.

COMPLICATIONS OF THE DISEASE ULCERATIVE COLITIS AFTER ILEOSTOMY

It is customary for most patients with ulcerative colitis to do well after ileostomy, but one may see exacerbations of the disease at any time. There may be a recurrence of purulent or bloody discharge from the colon and rectum; there may be a peritonitis from a perforation of one of the ulcers; there may develop an arthritis involving any of the joints, or there may be evidence of a smouldering toxic process with anemia, weight loss and general poor health. With any of these manifestations it is wise to do a colectomy, but, of course, with a peritonitis the colectomy must be postponed until this has completely subsided.

Cattell has recently stressed the increased incidence of carcinoma in ulcerative colitis and one realizes how difficult the diagnosis may be in a case where an ileostomy has been performed and the entire large bowel defunctioned. It is not unusual for polyp formation, predominantly of the pseudo type, to occur in an ulcerated colon and it may be very difficult to differentiate the pseudo polyp from an early carcinoma. I have seen competent pathologists disagree on the microscopic diagnosis of such a lesion. It is my own opinion that marked polyp formation is an indication for resection. If resection is not carried out, one should bear in mind the possibility of a carcinoma developing in the colon or rectum and the patient should be followed closely.

Impotentia

Endocrine therapy has been used extensively, but if the glands are not impaired or deficient, they will not respond to such stimulation. Testosterone is given in doses ranging from 25 mg. three and four times a week, depending upon the extent of the endocrine pathology or deficiency. —Keshin & Pinck, New York City; N. Y. State Jrnl. of Med., Vol. 49, No. 3, Feb. 1, 1949.

Cystic Disease of Liver and Kidney: Report of a Case

RAOUL W. URICH, M. D.

A TWENTY-FIVE-year old white woman was admitted to University Hospital in labor. The patient had one other child, which was living and well. Her present course of gestation had been uneventful. At the time of admission fetal heart tones were heard in the lower left quadrant and were timed at 140 per minute. The fetal membranes ruptured at 9:30 p. m.; one-half hour later rhythmic uterine contractions began, accompanied by profuse vaginal bleeding. A vaginal examination revealed a marginal placenta praevia. However, labor continued normally, the patient receiving intravenous plasma and saline. At 5:30 a. m., on the next day the cervix was completely dilated, the fetal heart tones were still 140 and strong. One hour later the patient was delivered by low forceps; the infant was dead.

AUTOPSY

Gross Examination: The body was that of a newborn infant; it measured 31 cm. from crown to rump and weighed 2000 gm. The skin was cyanotic and a small cephalhematoma was present. Except for a protuberant abdomen, no visible abnormalities were present. The enlargement of the abdomen was found to be due to a great increase in the size of the liver, which had elevated the diaphragm and partly compressed the lungs. The visceral relations were otherwise normal.

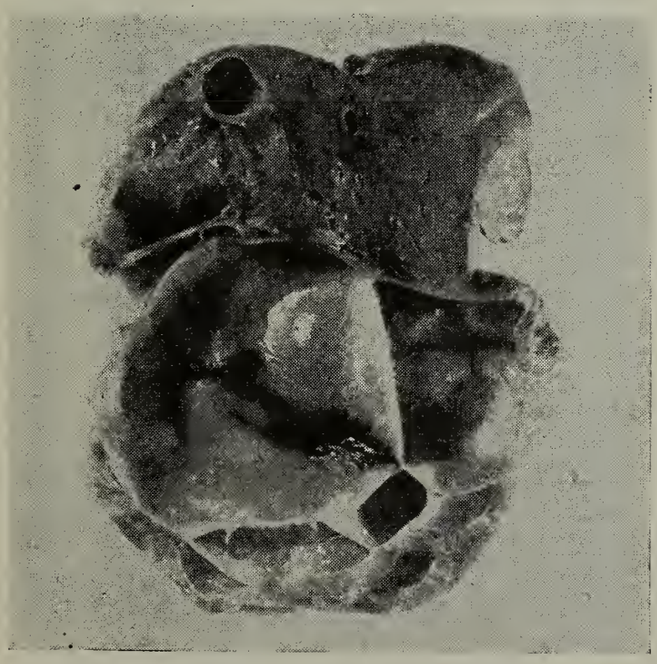


Figure 1. A coronal section through the liver showing a large multiloculated thin-walled cyst occupying the lateral half of the right lobe. A similar cyst is seen arising from the inferior margin of the liver.

The liver weighed 600 gm. and measured 14 x 13 x 4 cm. The lateral half of the right lobe was occupied by a large multiloculated thin-walled cyst. Arising from the inferior border was a similar cyst that measured 8.5 x 12.5 x 4 cm. and almost filled the abdominal cavity (Figure 1). The cysts contained a pale yellow watery fluid.

The right kidney weighed 70 gm., measured 9 x 6 x 2 cm., and consisted of a mass of thin-walled cysts (Figure 2). Clear yellow or dark brown fluid was present in the cysts. The left kidney weighed 15 gm. and measured 5 x 3 x 1.5 cm. The capsule stripped with ease, exposing a

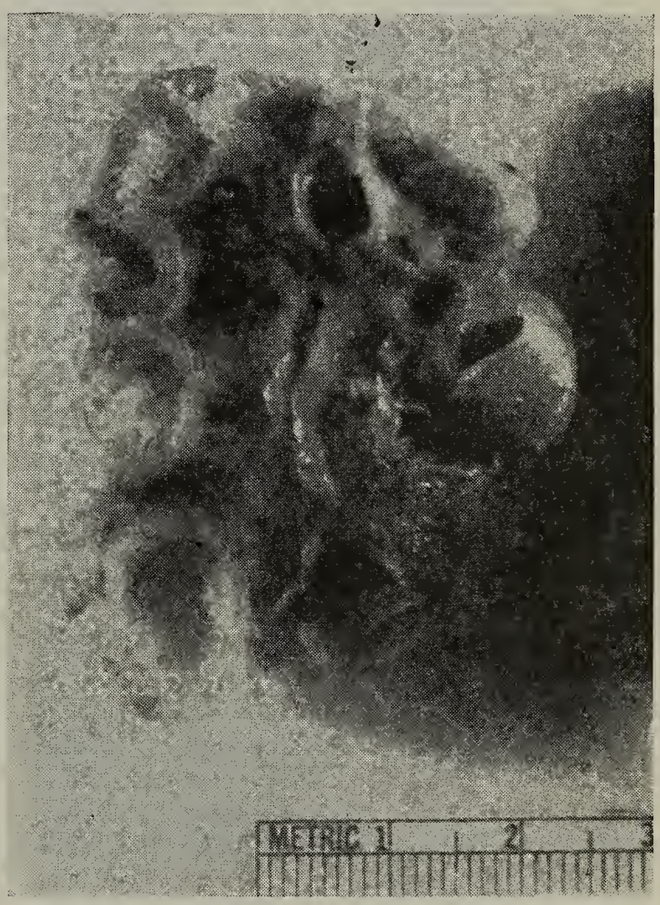


Figure 2. Longitudinal section through the right kidney. The renal parenchyma has been almost wholly replaced by thin-walled cysts; pelvis and calyces cannot be identified.

smooth lobulated surface. On section, numerous cysts were found in the cortex. Both ureters were free of strictures or dilatations. The bladder contained 25 cc. of clear yellow urine; no diverticula were present, and the ureteral and urethral orifices were normal. The remaining abdominal organs as well as the heart and lungs, were free of abnormality.

The fluid contained within the hepatic and renal cysts was analyzed for urea nitrogen and creatinine; direct and indirect van den Bergh determinations were also performed. The fluid from the liver contained 20 mg. per cent of urea nitrogen and 0.8 mg. per cent of creatinine. The direct van den Bergh showed 0.65 mg. per cent of bilirubin, the indirect 1.55. Fluid from the kidney cysts showed a urea nitrogen level of 22.0 mg. per cent and creatinine of 1.0

From the Department of Pathology, College of Medicine, Ohio State University, Columbus, Ohio. Submitted July 26, 1948.

mg. per cent. The direct van den Bergh was 0.0, the indirect 0.07. These values fail to reveal evidence of any functional differentiation on the part of the cyst epithelium either in the kidney or the liver.

Microscopic Examination: The cysts of the liver were lined by flattened epithelium and surrounded by connective tissue which in some areas was dense and hyalinized. Areas of myxomatous change were also present. Within the connective tissue were numerous proliferating bile ducts. The liver cells appeared normal; extramedullary hematopoiesis was active. The cystic spaces were also lined by flattened or cuboidal epithelium surrounded by loose connective tissue. Within this fibrous stroma were occasional islands of normal kidney tissue. The histologic pattern in both organs is compatible with the current concept that in the case of the liver the cysts are due to dilatation of the bile ducts, and in the kidneys to distention of the renal tubules. In these sections there is no evidence of a preexisting inflammation.

DISCUSSION

The cysts of congenital polycystic kidneys may be classified into the following types: (1) The glomerular cyst, which is a dilated capsule of Bowman containing a vascular tuft and usually lined by flattened epithelium; (2) cystic dilatations of the proximal tubules; (3) cysts of the collecting tubules; (4) isolated cysts without vascular tufts or tubular connection; (5) lymphangiomas, lined by endothelium and filled with coagulated protein; (6) hemangiomas, lined by endothelium and containing red blood cells.

Virchow[1] offered the explanation that prenatal inflammation with resultant fibrosis could account for the formation of the tubular cysts. Later writers[2, 3] believed a more plausible explanation to be that the cysts resulted from a failure of union between the convoluted tubules and the collecting tubules during development. Another theory recalls that during embryogenesis some tubules empty into the developing calyces; normally these tubules regress completely. McKenna and Kampmeier[4, 5] have suggested that rarely they may persist as rudiments and give rise to cysts. Lambert[6] has found by reconstruction of cystic nephrons that glomerular cysts exist as closed vesicles, while some tubular cysts are connected with excretory ducts and the renal pelvis. He concludes that when the cysts and excretory ducts are not united, the failure of continuity may be secondary to the development of the cyst rather than the primary cause of the cystic dilatation. Another explanation has been offered by Norris and Herman.[7] These authors point out that all tubules of the mesonephros and many of the early embryonic tubules of the permanent kidney undergo segmental degeneration. They suggest that the cystic kidney represents a continuation of this degenerative process.

Although polycystic kidneys may occur without cystic disease of other organs, in many cases careful microscopic examination will reveal such cysts. Besides the kidneys, the liver is the organ most frequently affected. Cysts of the liver without renal involvement are for the most part solitary, located in the region of the ligamentum teres, and lyphangiomatous in origin. Single cysts elsewhere in the liver may be due to chronic inflammation or represent hamartia of the ducts.[8]

Multiple cysts of the liver are due to dilatation of the intrahepatic bile ducts. The cysts are lined by cuboidal or flattened epithelium and surrounded by dense connective tissue. The area adjacent to the cyst contains branches of the hepatic artery and portal vein as well as distorted and proliferating bile ducts. Although the lobular architecture of the liver is not disturbed, it has been noted that the number of bile ducts in the periportal spaces frequently appears to be increased. This has suggested the possibility that during embryogenesis there is an excessive production of bile ducts. Since some of these supernumerary ducts end blindly, their persistence and dilatation may lead to the subsequent production of cysts. It has also been proposed that, as in the kidney, the development of hepatic cysts is due to the abnormal extension of segmental degeneration of the bile ducts.[9]

No cysts were found in the pancreas or lung of the case reported. Cysts of these organs frequently occur with cystic disease of the liver or kidneys. The pathogenesis is believed to be similar to that in liver and kidneys; viz., segmental degeneration of the epithelial tubules with subsequent dilatation.[10]

SUMMARY

1. A case of polycystic disease of the liver and kidneys in a full-term stillborn infant is presented.

2. Various theories of the pathogenesis of polycystic disease are discussed.

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Tuberculosis Abstracts

A Review for Physicians Issued Monthly by the National Tuberculosis Association

UNTIL army maneuvers exposed many thousands to the disease, coccidioidomycosis was confined chiefly to a few scattered areas in the southwestern part of the United States. Infected individuals are now widely disseminated and the fact that the pulmonary lesions resemble those of tuberculosis with which it may be coexistent increases the difficulty of recognition.

The following is a case report in which caseous pneumonic tuberculosis with cavitation developed in a patient with coccidioidal cavity in the opposite lung. Had the previous medical history not been known, the finding of tubercle bacilli in the sputum together with the X-ray picture would have led to a diagnosis of bilateral cavity tuberculosis, and the coccidioidomycosis would have been overlooked.

This case raises the question whether it would not be wise to do routine examinations for both coccidioides immitis and tubercle bacilli in all cases of pulmonary disease with cavitation. This suggestion is in line with the conclusions reached by other investigators.

CASE REPORT

1. F., a 24-year-old Negro, was admitted to the hospital in December, 1945. Pulmonary tuberculosis had been diagnosed on routine X-ray examination at a separation center that showed infiltration in both apexes and in the right third anterior interspace.

During the war the patient had taken part in desert maneuvers in southern California from June to December, 1943, but had had no respiratory illness. The past medical history was noncontributory. The family history was negative for tuberculosis.

On admission the only complaint was intermittent, slight pain in the left side of the chest for the past few months. Physical examination revealed a well-developed man who did not appear ill. There was no dyspnea or cyanosis, and examination of the heart and lungs was negative. X-ray examination showed minimal infiltration in both apexes. Planigrams showed a small thin-walled cavity just above the right clavicle.

Significant laboratory findings were as follows: A tuberculin skin test using purified protein derivative was negative in the first strength and weakly positive in the second strength. Coccidioidin skin test in a 1:1000 dilution was negative on two occasions. Sputum concentrates, examination of the gastric contents, one sputum culture and one guinea-pig inoculation were negative for tubercle bacilli. One 72-hour concentrate was negative for fungi. The sedimentation rate was 8 mm. in one hour. Urinalysis showed a trace of albumin. Blood counts were within normal limits.

The patient left the hospital against advice in March, and the discharge diagnosis was chronic pulmonary tuberculosis, moderately advanced.

The patient returned to the hospital on June 13, with the chief complaint of bilateral chest pain and a slightly productive cough. Physical examination and X-ray films of the chest showed no essential change since the previous admission. There was the same isolated, thin-walled cavity in the right apex and a small area of infiltration in the left apex.

A coccidioidin skin test was positive on July 2 in a 1:1000 dilution and positive on July 5 in a 1:100 dilution. Sputum studies for acid-fast bacilli, including seven direct smears, five concentrates and three gastric lavages, were negative. On July 15 the sputum was found to contain spherules of coccidioides immitis on direct smear, and this was confirmed by culture on July 20. Serologic tests for active coccidiodomycosis were performed. The complement-fixation test was four plus in 1:2 and 1:4 dilutions. The precipitin tests were all negative. It was concluded that the findings indicated a coccidioidal infection. His symptoms subsided and he was discharged on February 19, 1947. He returned seven months later because of weight loss and hemoptysis. X-ray showed cavitation in both upper lobes. Sputum examination showed acid-fast bacilli on both smear and culture. Serologic tests for coccidioidal infection were repeated at this time. The complement-fixation test was four plus in dilutions of 1:2, 1:4 and 1:8 and two plus in a dilution of 1:16. The precipitin tests were negative in all dilutions. These results were interpreted as not being high enough to indicate a coccidioidal dissemination. Coccidioides immitis was again found in the sputum on smear and culture.

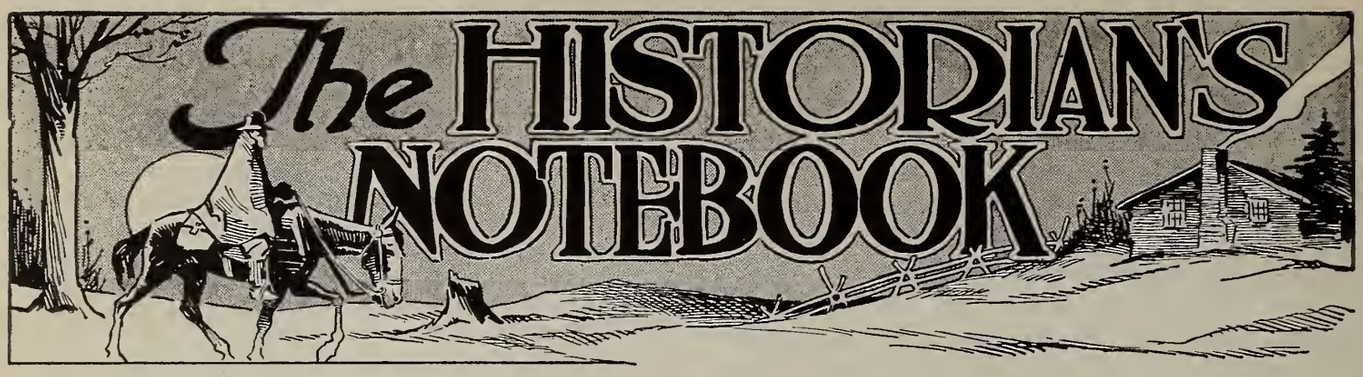
The patient left the hospital against advice on November 1, before streptomycin therapy could be instituted.

SUMMARY

A case is presented in which coccidioidal cavitation was observed for fifteen months in a patient who subsequently developed a caseous cavitary tuberculosis in the opposite lung, with a positive sputum test for tubercle bacilli.

That tuberculosis and coccidioidomycosis may both cause pulmonary cavitation is now a well-known fact. Since the diseases may coexist in the same patient, it is advisable to check routinely for both tubercle bacilli and coccidioides immitis in all patients with pulmonary cavitation.—*Coexisting Pulmonary Coccidioidomycosis and Tuberculosis, Lieutenant Robert S. Study (M. C.) U. S. N. R. and Philip Morgenstern, M. D., New England Journal of Medicine, June 10, 1948.*

It is clear in all of this talk of nutrition in medical practice that two aspects are apparent, a preventive or protective aspect, and a curative aspect. The preventive or protective aspect, while clear enough in certain instances such as scurvy and rickets in infants, is less apparent in regard to some of the other situations.—J. B. Youmans, M. D., Wisc. Med. Jrnl., Vol. 48, No. 2, Feb., 1949.



The Doctor As Poet

EDWARD PODOLSKY, M. D.

FROM time immemorial there has been an intimate relationship between medicine and poetry. Apollo, the god of poetry, was the father of Aesulapius, the divinity of the healing art, and in Greek times those practicing medicine were dignified as "the children of Apollo." The figure of Apollo, the supreme god of medicine, together with the Muses and the serene goddess Pallas Athene, the immortal exemplar of reason and discipline, are the most ancient personification of all the great intellectual virtues.

Both poetry and medicine go back to the childhood of the race. For while "poetry, like Beatrice, was born under a dancing star," medicine came into being with the first struggles for existence. They have been man's spiritual companions all down the long journey.

Probably the earliest physician-poet was Floridus, who lived in France in the Ninth Century and wrote a lengthy collection of hexameters about the medical virtues of plants. The most famous poem of this type is the *Regimen Sanitas* written at the medical school of Salerno about 1101, its author probably one John of Milan. This work was addressed to the lay public, was one of the earlier printed books in 1480. It passed through many editions.

The writing of verse by physicians, mostly epigrams and didactic epics, was common during Greek and Roman times. Nikandros of Kolophon (circa 133 B. C.), the son of a priest of Apollo, and himself a physician, wrote two works of poetry of considerable length dealing with medical themes. Macer, in the Third Century A. D., wrote a materia medica in verse.

The Golden Age of English poetry which began with Edmund Spenser's *Shepherd's Calendar* in 1579, and gave to the world the glorious varied plenty of Elizabethan poetry, finds two physicians in the list of famous names, each of whom has given us some of the loveliest lyrics in the language. These two men are Thomas Lodge and Thomas Campion. Thomas Lodge (1558-1625), the son of Sir Thomas Lodge, Lord Mayor of London, first tried his hand at law, then for a time was soldier, literary man, and later freebooter in the Spanish Main and Brazil. He finally turned to medicine and graduated from Avignon and Oxford. He began practice in Warwick Lane, London, was successful as a physician and continued to write. Lodge in his practice of medicine was somewhat of an authority on the plague, from which he died in 1625. It is Lodge's most famous poem, *Roselynde, Euphues, Goldren Legacie*, that provided Shakespeare with his material for *As You Like It*. Lodge's chief volume of verse was *Phyllis* (1593), which contained some forty sonnets and lyrics and a long narrative poem. He is remembered by his little songs and madrigals, two or three of which, such as *Rosalind's Madrigal*, still find a place in every anthology of English verse.

Thomas Campion (? -1619), poet, musician and doctor of medicine, was born about the middle of the Sixteenth Century. Like Lodge, he was first of all a student of law in London, later turning to medicine and graduating from Cambridge. He had a most successful practice in London, and was a cultured, urbane man, with a wide circle of friends. His lyrics are perfect and exquisite examples of their kind. Campion was quite prolific as a poet and his poetry was widely read in his time. He was one of the really great early doctor-poets.

SEVENTEENTH CENTURY

Abraham Cowley (1618-1667), a native of London, scholar of Trinity College, Cambridge, and later of Oxford, spent his earlier years in the Royalist cause, living for a time in France

Submitted February 3, 1949.

as secretary to the exiled Queen Henrietta Maria. In 1657 he became a doctor of medicine. During his life time he was regarded as the greatest English poet, and on his death was buried in Westminster Abbey. In literary history, Dr. Cowley is remembered as one of the first to establish what may be termed the modern prose style.

The next figure, Henry Vaughan (1621-1693) is one for whom poetry is deeply in debt to medicine, Vaughan, the "Silurist," as he was called because of his native place among the Silures in the county of Brecknockshire in South Wales, was educated at Jesus College, Oxford, and was a staunch Royalist, being imprisoned for a time during the British Civil War. He practiced medicine in his native land and achieved a considerable reputation. His literary work was an avocation pursued for the love of writing. His poem *The Retreate* provided Wordsworth with some part of his inspiration for the famous *Ode on the Intimations of Immortality.* Some half dozen of his poems are the finest expression in our language of spiritual aspiration. As a writer of religious verse he is of the company of George Hebert and John Donne.

Two lesser names complete the role of Seventeenth Century physician-poets. Martin Llewellyn (1616-1682), scholar and cavalier, fought for the Royalist cause and afterwards practiced in London. Later he became a Fellow of the Royal College of Physicians, and with the Restoration he was made physician to Charles II and Principal of St. Mary's Hall, Oxford. His best known work was *Mere Miracles.* In his scientific work he is regarded as the founder of comparative helminthology (worms and parasites as the causes of disease) and he did much to refute the theory of spontaneous generation. He was a distinguished poet in his day, publishing *Bacco in Toscane, Arianna Inferma,* and other works.

EIGHTEENTH CENTURY

With the single exception of Oliver Goldsmith, the physicians of the Eighteenth Century produced little poetry of worth. In passing we may mention two physician-poets, John Wolcot and Mark Akenside. John Wolcot (1738-1819) who wrote under the pseudonym of Peter Pindar, figured in some of the literary quarrels of his day. He had great satirical ability, but his humor at times was rough and libellous. His poem *Satyr Against Wit* brought attacks from Dryden, Pope, Steele and Garth.

Mark Akenside (1721-1770) became physician to the Queen and was a very distinguished medical man. He dabbled in poetry and attained some degree of favorable notice. His principal work, *The Pleasures of the Imagination,* is a long didactic poem in blank verse. He also wrote many odes in the manner of Gray and Collins. His arrogant manner made him many enemies, and probably on this account he was satirized by Smollett in *Peregrine Pickle.*

The greatest of the Eighteenth Century doctor-poets was Oliver Goldsmith (1728-1774). After graduating B. A. at Trinity College, Dublin, and spending several advances of money from his family in an attempt to get out of Ireland, he turned up in Edinburgh where he studied medicine. He then wandered over Europe, playing on the flute and debating at the universities for a livelihood; returned to England where he practiced medicine. His attempts at practice were as happy-go-lucky and as prodigal as his nature. He at length gave up medical practice altogether and began to devote all his time to literature.

Goldsmith's contributions to poetry are immortal. His, *The Deserted Village,* is one of the greatest poems of all times and many of its couplets have become part of our daily speech.

NINETEENTH CENTURY

The roll of Nineteenth Century medical poets opens with the name of the greatest poet in English literature, John Keats (1795-1821). As a modern writer has said: "Medicine suffered a loss, but the world gained when this prodigal son strayed off into a far country."

John Keats, a spirited pugnacious lad, and a natural leader among his fellows, was left an orphan at the age of fourteen. In the following year he was apprenticed by his guardian to Mr. Hammond, a surgeon of Edmonton, in whose service he spent more than four years. The young apprentice already had a passion for literature, and during these early years completed a translation of the *Aenid.* But it was the reading of Spenser's *Faerie Queen,* through which he ranged with delight, that awakened his genius, and his earliest compositions are in imitation of Spenser. The earliest sign that Keats had seriously committed himself to poetry occurred in February, 1815, when he impulsively handed his friend, Clarke, a sonnet, entitled *Written on the Day that Mr. Leigh Hunt Left Prison.* He was in his nineteenth year at the time and still an apprentice. While none of these earlier efforts were precocious, in midsummer of this same year there was a sudden blaze of genius. Keats and Clarke had read a borrowed folio copy of Chapman's *Homer* far into the small hours of the morning. Keats who left for home in a state of excitement, composed and sent back a sonnet which Clarke found on his breakfast table when he came down in the morning. It bore the title *On First*

Looking Into Chapman's Homer, and is one of the perfect poems in English literature.

In this poem the young apprentice for the first time "speaks out loud and bold," in accents which were to widen the boundaries of those very realms "which bards in fealty to Apollo hold." Poetry was already the interest of his heart.

However, he passed with credit his examination as licentiate at Apothecaries'. Hall on October 1, 1815, to continue his studies. He was a diligent student, sufficiently outstanding to attract the attention of Sir Astley Cooper, one of the leading surgeons of the day. During the first winter and spring in London he lived the typical drudging life of the medical student, rooming with two fellow students in dingy lodgings in the Borough near Guy's Hospital. While here he wrote the two sonnets:

"O Solitude! If I must with thee dwell,
Let it not be among the jumbled heap of
murky dwellings."

and—

"To one who has been long in the city pent,
'Tis very sweet to look into the fair
And open face of heaven. . . ."

In the course of his first year as a student at Guy's, Keats moved to lodgings over a tallow-chandler's shop in St. Thomas's Street. Here one evening while his fellow-student Stephens was studying, Keats broke out with the announcement that he had composed a new line of poetry:

"A thing of beauty is a constant joy."

To Keats's inquiry Stephens replied that he liked the line, but it seemed wanting in some way. After an interval of silence came Keats' rejoinder:

"A thing of beauty is a joy forever."

And so there was in the little room of a trio of medical students "one of the imperishable lines of English poetry."

Keats continued to do his work regularly and with considerable credit. But the poet was crowding out the medical student. As he himself says: "The other day, during the lecture, there came a sunbeam into the room, and with it a whole troop of creatures floating in the ray, and I was off with them to Oberon and fairy-land." He worked as a dresser, but always seemed curiously apart from the work. He later told a friend: "My last operation was the opening of a man's temporal artery. I did it with the utmost nicety, but, reflecting on what passed through my mind at the time, my dexterity seemed a miracle, and I never took up the lancet again." He qualified with credit in July, 1816, but after a holiday at Margate returned to London resolved to write poetry, and with the ambition to be among the great. Medicine was already forgotten, and with an intensity which few poets, even the greatest have shown, Keats gave himself up to his work as a writer.

Medical practice was never distasteful to him; he never showed for it the dislike with which so many genuises have regarded the more work-aday vocations. To him it was like sojourning in a far country.

Keats wrote poetry all the years of his too brief life. To him who longed for freedom from torment, death came peacefully on Friday, February 23, 1821. On Sunday morning they carried him to the Protestant Cemetery in Rome and laid him to sleep amid the ruins of the old Aurelian Wall. He was in his twenty-sixth year. And Shelley wept bitterly for his youth, his loveliness, his unfinished expectation, his elemental majesty.

"He has outsoared the shadow of our night;
Envy and calumny, and hate and pain,
And that unrest which men miscalled delight,
Can touch him not and torture not again."

A poet-physician whom many have hailed as the successor of John Keats was Thomas Lovell Beddoes (1803-1849). Beddoes was the son of a celebrated English physician, and after leaving Oxford, went to the Continent where he received his medical degree from the University of Wurzburg. An orderly life was constantly shattered by his becoming involved in political intrigue. He finally committed suicide at the age of forty-six.

Beddoes' works are cast mostly in the form of the poetic drama. He is an Elizabethan dramatist of the company of Marlowe and Green, born out of season. His chief work is the play *Death's Jest Book,* upon which he worked for more than twenty years. It is the greatest dramatic variant in English on the old Dance of Death theme which has haunted painters and writers for centuries. The scenes are crowded with murder, ghosts, skulls, all cast with a strange beauty that is peculiar to Beddoes. His is the concentrated grim irony and harsh mirthless laughter of one who is preocuppied with death. The dark background of the play is lit up with an unearthly beauty by many haunting lyrics and dirges.

Early Pertussis Immunization

Although infants under six months of age do show significant antibody titers with injections at weekly intervals, more significant titers are obtained with injections at monthly intervals. The latter procedure is probably advisable in private practice where the infant can be protected from exposure by a controlled environment—E. N. Ervin, M. D., Jrn. of Maine Med. Assn., Vol. 40, No. 1, Jan., 1949.

Study of Child Health Services . . .

Ohio Pediatricians Submit Findings on the Nature of Medical Care Children of State Are Receiving, as Part of Nation-Wide Project

FIRST INSTALLMENT

FOREWORD

IN an attempt to discern the nature of the medical care being received by the children of Ohio, pediatricians of the State have completed, as part of a nation-wide project of the American Academy of Pediatrics, a study of child health services and facilities. During the year May, 1946, to May, 1947, each physician, dentist, hospital, and health agency in Ohio was asked these questions: "What medical care do you render children?" "How are you equipped to render this care?" "Who receives the care you give?"

The method of the study was that of the mailed questionnaire together with personal visits to hospitals. Because of the antipathy of busy physicians and other medical personnel to this method, the first three months of the study were given over to publicizing the proposed activities of the survey group. During those three months an office for the conduct of the study was set up in rooms donated by the Children's Hospital of Columbus, and preparations were made for the handling of the more than 60,000 pieces of mail necessary for collecting the desired information.

Beginning in August, 1946, questionnaires were mailed to dentists, pediatricians, other physicians, and to all known voluntary and official health agencies. During the Fall months visits were made by pediatricians to all hospitals caring for children for the purpose of collecting special information. The mail campaign called for many follow-up attempts to get information from interrogated subjects and this endeavor consumed the early months of 1947.

The Ohio Study was conducted through the activities of three main groups. First was the State Chairman with his Study Committee consisting of practicing pediatricians from various parts of the State. This group met at frequent intervals, usually on Sunday mornings, at the Columbus Children's Hospital during the course of the study. It was they who determined the policies to be followed in carrying out the survey and each man acted as a district chairman in his own part of the State, arranging meetings of local pediatricians with the executive secretary of the study, enlisting the support of his fellow pediatricians in the conduct of the study, and publicizing it in his neighborhood.

Second was the executive office of the study which was headed by an executive secretary, a pediatrician. He was assisted by an administrative secretary and an office force of from two to five other persons. This office developed and maintained contact with interested professional and lay groups throughout the State, conducted the publicity campaign of the study, did the actual work of preparing letters and questionnaires for mailing according to a very well-organized plan developed by the central office of the nation-wide study, and carried out extensive follow-up activities in an endeavor to get the greatest possible response to the questionnaires.

Editor's Note:—On authorization of The Council, The Ohio State Medical Journal will publish in installments a report covering a study of child health services and facilities in Ohio, made by Ohio pediatricians who are members of the American Academy of Pediatrics which has sponsored similar studies in many other states. The accompanying article is the first installment of the report. The report was compiled by those actively engaged in the study and any conclusions or findings appearing therein are those of the study committee.

Third was the Advisory Committee consisting of representatives of semi-professional and lay groups interested in child health. This committee met twice during the study and functioned chiefly as a channel of information from the study group to the membership of the organizations which they represented. Three of the groups represented on the Advisory Committee gave financial support to the Study.

This study was in actuality carried out by a group of practicing physicians headed by the Ohio members of the American Academy of Pediatrics with the assistance of a great many other individuals and groups. Credit must be

given to all who helped. The Ohio Department of Health gave extensive assistance both financial and otherwise. The Director of Health, the Chief of the Division of Child Hygiene, the Chief of the Division of Dental Hygiene, and the Chief of the Division of Nursing all gave invaluable aid. Ohio Chapters of the National Foundation for Infantile Paralysis, the Ohio Tuberculosis and Health Association, and the Ohio Society for Crippled Children, Inc., gave financial support to the study as did also the William S. Merrell Company of Cincinnati, and many individual pediatricians. The Ohio Tuberculosis and Health Association gave personal assistance in the field also. The Ohio State Medical Association and the Ohio State Dental Society gave early and valuable assistance to the work. The Ohio Hospital Survey, an activity of the Ohio Department of Health, graciously offered to assist in the collection of information from hospitals. Much help was given by representatives of the central office of the Academy Study upon their periodic visits to Ohio.

In presenting the report which follows, the Study Committee of the Ohio Study of Child Health Services presents the factual material compiled during the survey. It is believed that the material is based upon an adequate sample of the State's physicians, dentists, hospitals, and health agencies. Questionnaires were returned by 73 per cent of all dentists and 77 per cent of all physicians who received them. The percentage of returns from hospitals and health departments was above ninety.

—E. V. Turner, M. D., Executive Secretary,
Ohio Study of Child Health Services.

* * *

LETTER OF APPRECIATION

The Study of Child Health Services in Ohio, consisting of the survey of available personnel and physical facilities and the writing of the report, has been accomplished through the active participation and cooperation of many individuals.

The thought of having to perform such a task in the fourth largest State in the Union seemed insurmountable, especially to one who had had no experience in this type of work. But a kind Providence directed to Ohio at the opportune time individuals with experience and a willingness to accept the challenge.

There are many persons to whom I am grateful and to whom I give my sincere appreciation for their help in whatever form it was given. The personnel in the Central Office of the National Study in Washington gave valuable suggestions on how to organize the work and to get it started. The members of the Study Committee served faithfully. They drove great distances to attend committee meetings throughout the entire study and gave generously of their time and advice. They also aided in financing the study. The members of the Committee are: Doctors Robert B. Hauver, Cleveland; Isadore R. Cohn, Toledo; George C. Malley, Zanesville; Wallace B. Taggart, Dayton; John E. Brown, Jr., Columbus; James G. Kramer, Akron; and J. Victor Greenebaum, Cincinnati.

Dr. Edward V. Turner was the Executive Secretary and Miss Mary E. Holton, his assistant. They organized the office staff, outlined the work, and attended to the many details necessary to accumulate the large volume of information obtained. Their experience in work of this kind and their interest in it aided greatly in getting the task done, and to them is due much of the credit for its accomplishment. Mr. R. M. Porter, Superintendent of The Childrens Hospital of Columbus, graciously gave space in the hospital for the office of the Study. This central location made it possible for the Secretary to reach any section of the state easily.

The Ohio State Department of Health, through Dr. Susan P. Souther, Chief of The Division of Child Hygiene, gave splendid cooperation in an advisory capacity. The Department also provided funds and equipment for the survey, and made funds available for the publishing of the detailed and popular reports.

The Ohio State Medical Association permitted the use of its membership file for the survey. The Executive Secretary, Mr. Charles S. Nelson, gave sound advice and aided in publishing the report in *The Ohio State Medical Journal.* The Ohio Dental Society cooperated in the survey by opening its membership file and by publicizing the Study in its Journal.

A Study of this kind cannot be done without money. Financial support came from several sources. These are listed in the Foreword. To all of them I give my thanks for contributing generously. To the Advisory Committee also I am grateful for their interest and support.

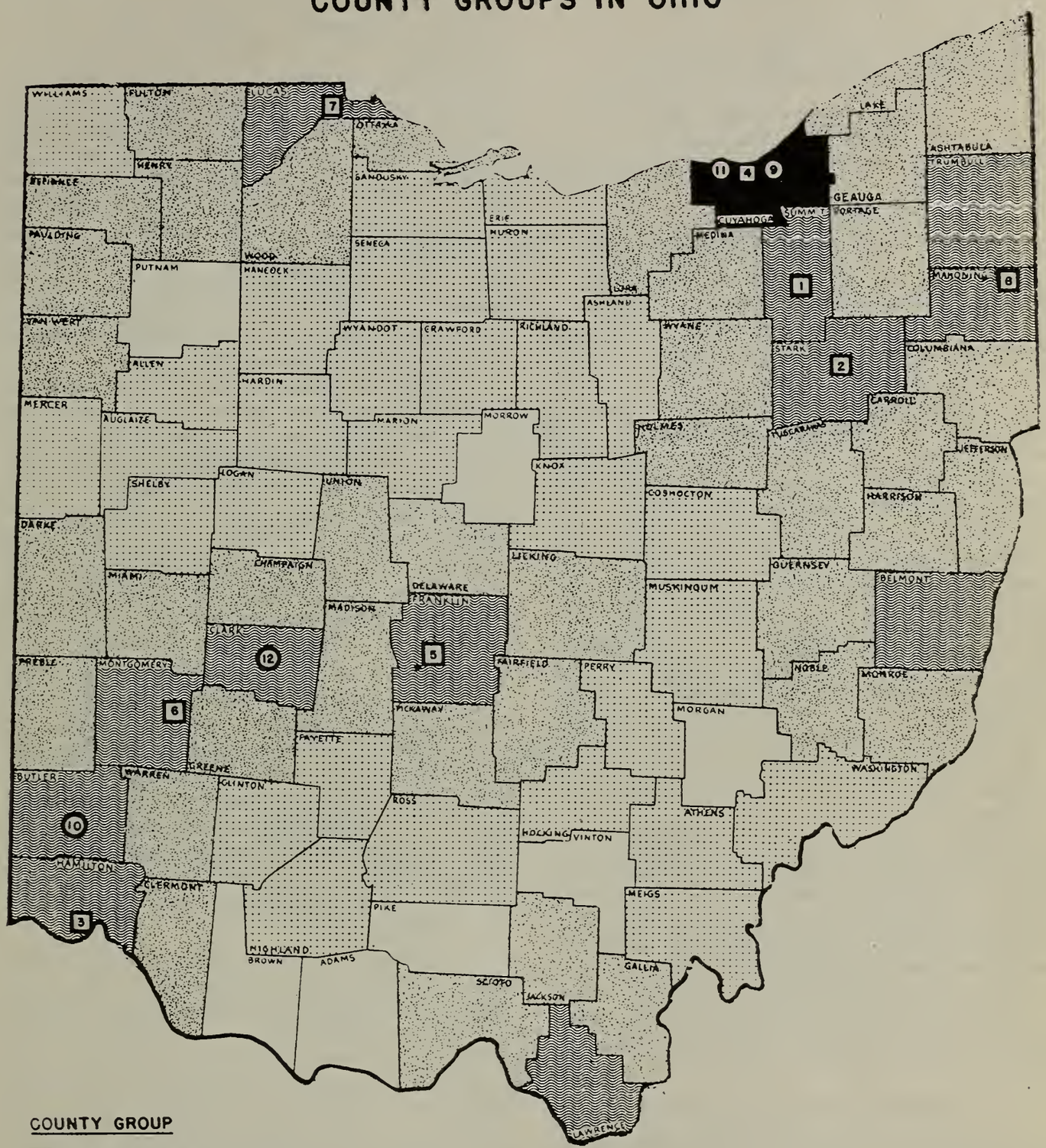
Much credit must be given for the support received from the physicians, dentists, hospital personnel, and the personnel of the health agencies who took time to fill in questionnaires. Without this help from these thousands of individuals, the work could not have been completed. These "little tasks make large return." Surely this is true, for the completion of these little tasks by many make the whole work more meaningful and valuable.

Dr. Margaret H. Doyle aided greatly in analyzing the many tables containing the data obtained from the questionnaires. She assembled the information, and wrote the report.

Then, to all of you again I say thank you, and I hope you derive some satisfaction in knowing

Figure 1.

COUNTY GROUPS IN OHIO



COUNTY GROUP

- GREATER METROPOLITAN
- LESSER METROPOLITAN
- ADJACENT
- ISOLATED SEMI-RURAL
- ISOLATED RURAL

CITIES 50,000 TO 100,000

9 CLEVELAND HEIGHTS
10 HAMILTON
11 LAKEWOOD
12 SPRINGFIELD

CITIES 100,000 OR OVER

1 AKRON
2 CANTON
3 CINCINATTI
4 CLEVELAND
5 COLUMBUS
6 DAYTON
7 TOLEDO
8 YOUNGSTOWN

that you had a part in this task, which I trust will aid in improving child health in Ohio.

The things that haven't been done before,
Those are the things to try

Somebody said that it couldn't be done,
But he with a chuckle replied,
That "maybe it couldn't," but he would be one
Who wouldn't say so till he'd tried.—Edgar A. Guest.

—Benjamin Hoyer, M. D.,
Ohio State Chairman,
American Academy of Pediatrics.

* * *

CHAPTER I—INTRODUCTION

The Study of Child Health Services under the direction of The American Academy of Pediatrics was undertaken so that an accurate evaluation could be made concerning the present status of the health and medical care of children within the United States. This report is concerned only with the facts compiled from the study which was carried out in Ohio during 1946-1947, and with pertinent comparisons of similar information from other states. This resumé of child health services in Ohio served as a basis from which the conclusions and recommendations were made by the Study Committee of the Ohio section of the American Academy of Pediatrics after a study of questionnaires completed by: (a) physicians and dentists; (b) voluntary and official community health agencies; and (c) all hospitals admitting children or maternity cases.[1]

These studies were conducted in a similar manner to the pilot study made in North Carolina so that there would be a basis of comparison among all states.

The data used for physicians' visits were obtained by having one-seventh of the physicians fill out schedules for each of the days of the week. Pediatricians' records covered a period of twenty-eight days, and schedules for community health services and hospitals covered one year.

Unless otherwise indicated, the term "children" in this report, refers to all persons under fifteen years of age, including newborn and premature infants.

COMPARISON WITH OTHER STATES

For a basis of comparison in the Ohio report, the values of services in the highest ranking state, the lowest ranking state, and the average of the United States, were used. This was done to indicate what can be accomplished under favorable conditions and what wide variations in the amount of services exist.

COMPARISONS WITHIN OHIO

The 88 counties of Ohio have been grouped in three ways for the sake of comparative studies to point out existing inequalities within the State.

First, they have been grouped under the headings of greater metropolitan, lesser metropolitan, adjacent, isolated semi-rural, and isolated rural. (Figure 1) A metropolitan county is one with at least one city of 50,000 or more inhabitants. Counties that touch a metropolitan county but are not themselves metropolitan counties, are grouped together as adjacent counties. Counties that do not touch any part of an above-defined metropolitan county have been subdivided into (1) isolated semi-rural counties which had at least one incorporated place of 2,500 or more inhabitants in 1940, and (2) isolated rural counties which had no incorporated place of 2,500 or more inhabitants in 1940. This method of grouping was used to conform with that of the other state reports so that comparisons could be made between similarly grouped counties in the various states.

Secondly, the Ohio counties were grouped according to geographic division, and thirdly, by per cent of rural population. The Ohio Study Committee felt that the classification of information according to the metropolitan character of the counties alone would not tell the whole story of health services for children in the State. Accordingly, the central office was requested to tabulate the Ohio data in two other ways: by geographical-economic sections of the State; and by rural character of the counties.

The State was divided into seven sections according to topography and more or less according to dominating economic interests. Section I includes the Lake Erie heavy-industries counties; II, the upper Ohio Valley heavy-industries counties; III, the rolling northeast agricultural counties; IV, the central plains agricultural counties; V, the northwest plains less agricultural counties; VI, the Miami Valley lighter-industries counties; and VII, the hilly poor lower Ohio Valley counties. (Figure 2)

It was felt that approaching the matter of health resources for children from the rural angle would highlight the need of those counties in which more than 30 per cent of the total population live on farms. It was the belief of the Committee that many rural counties, even though adjacent to metropolitan counties, do not use the facilities of their urban neighbors, and that they should be considered with other counties of similar population make-up. Therefore, the counties of the State were grouped into four groups: those in which the rural-farm population made up 50 per cent or more of the total; those with 40-49 per cent rural farm population; those with 30-39 per cent rural farm population; and those with less than 30 per cent rural farm population, according to the 1940 Federal Census. (Figure 3)

These last two classifications are given only when data were available. Comparisons within these two groups are of most value in pointing

Fig. 2 Geographic Divisions Of Ohio



out inequalities of services within the State of Ohio. As a matter of convenience, comparisons are given at the end of each chapter.

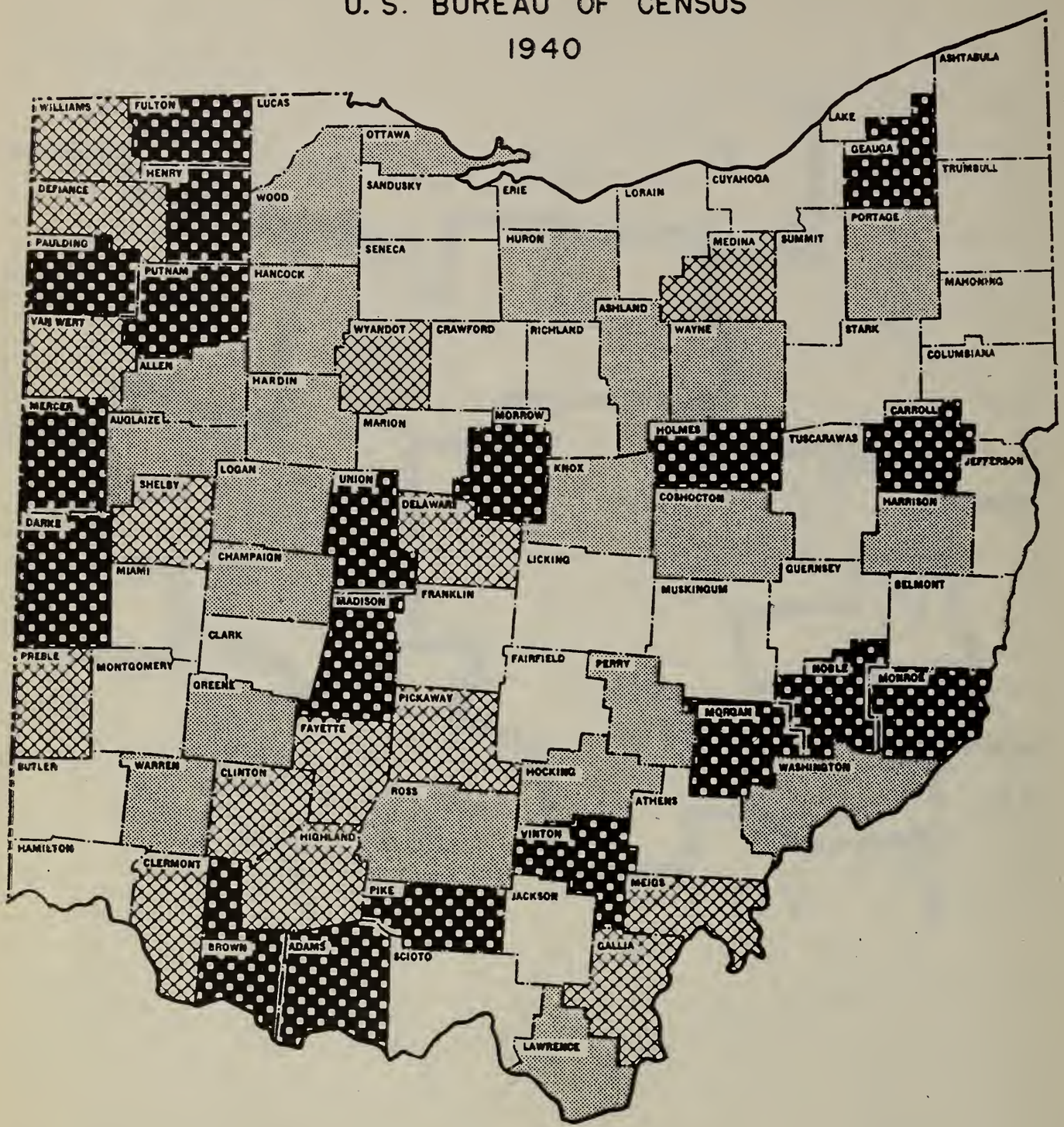
ECONOMIC, HEALTH STATUS OF CHILD

The financial resources of Ohio as compared with other states were well above average. The per capita income of $1,306 (1944-46) was exceeded by ten states. The highest per capita income, $1,579, was found in Connecticut and the lowest, $559, in Mississippi. The average per capita income in the United States was $1,141.[2] When the geographic groups of the State were ranked as to per capita income, the following was found: Group I ranked first; Group VI was second; Group II was third; Groups III, IV, and V had similar per capita income; Group VII was lowest with a per capita income approximately half that of Group I.

In Ohio a comparatively small proportion of the population was children; the total population in 1940 was 6,907,612, and the number of children

Fig. 3 RURAL CHARACTERISTICS OF OHIO COUNTIES

U. S. BUREAU OF CENSUS
1940



Rural Farm Population more than 50% Total Population

Rural Farm Population 40 to 49% Total Population

Rural Farm Population 30 to 39% Total Population

Rural Farm Population under 30% Total Population

was 1,578,860.[3] The percentage (23 per cent) of children was thirty-sixth in the country, the average being 25 per cent, the highest 35 per cent, and the lowest 20 per cent. Fifty-nine per cent of the children were in metropolitan counties (16 per cent in greater and 43 per cent in lesser), 23 per cent in adjacent counties, 16 per cent in isolated semi-rural, and 2 per cent in isolated rural in Ohio in 1945.

During the period 1941-1945 in Ohio, an aver-

Fig. 4 Trend of Infant and Maternal Mortality

Ohio, 1930-1947



SOURCE: DIVISION OF VITAL STATISTICS
OHIO DEPARTMENT OF HEALTH

age of 38 infants died for every 1,000 live births. By 1946 this rate had fallen to 31, and to 30 in 1947, indicating a definite improvement in the protection and care of infants. However, 16 states that year had lower rates; Utah's rate of 27 was the best. (Figure 4)

In Ohio during 1941-1945, the maternal death rate showed a steady decrease from 2.6 in 1941 to 1.7 in 1945. In 1947, this rate had fallen to 1.1. The maternal mortality rates for the United States in the same period were somewhat higher than for Ohio, being 3.2 in 1941 and 2.1 in 1945. However, in 1945, 23 states, excluding the District of Columbia, had lower rates, with Wyoming's rate of 0.9 being best.

Although the trend in infant mortality has been downward in the State as a whole, the rates in rural counties have shown a lag. This lag may be noted in Figure 5, which shows the infant mortality by county (three year average). (Figure 5 will be shown in Second Installment.)

During 1945, 87.6 per cent of live births in Ohio occurred in hospitals; the average for the United States was 78.8 per cent, and the highest for the country 98.4 per cent was in Connecticut. In 1946, this percentage had increased to 89.6 per cent for Ohio and 82.4 per cent for the United States average.

SUMMARY

1. Ohio was the eleventh wealthiest state in the United States with a per capita income of $1,306 in 1944-1946.

2. In 1940, 23 per cent of the total population of Ohio was made up of persons under 15 years of age. Eighteen per cent of the children were in isolated counties (isolated semi-rural and isolated rural).

3. The Ohio infant mortality rate showed improvement from 38.4 in 1941-1945 to 31.3 per 1,000 live births in 1946. Wide variations in this rate in the various counties of the state were brought out.

4. The percentage of infants delivered in Ohio hospitals is increasing; in 1945, the percentage was 88 and in 1946, 90.

REFERENCES

1. Details other than these contained in this brief report may be obtained by application to the State Chairman of the Academy of Pediatrics.
2. Calculated from estimates of income made by Sales Management for 1944-1946. Sales Management, Vol. 54, No. 10, May 15, 1945, and corresponding issues 1946 and 1947.
3. 1940 data used since that is the last year for which data are available.

(To be continued in May issue)

Medical Practice in Britain . . .

American Physician With More Than Six Years Medical Experience in The British Isles Gives Eye-Witness Account of State Operated System

PHYSICIANS will be interested in the following "inside story" of the socialized medical program now being practiced in Great Britain, because it was written by an American doctor who had more than six years of medical experiences in that country. The author is Dr. William H. Sweet, assistant professor of surgery, Harvard Medical School; lecturer in neurosurgery, Tufts College Medical School; and associate visiting neurosurgeon, Massachusetts General Hospital. Dr. Sweet stated: "I have spent two years as an Oxford medical undergraduate, four years in London and Birmingham during the war as a practicing surgeon, employed by the Ministry of Health for most of this time, and a further recent period of work in England." The article is reprinted from *The New England Journal of Medicine.*

* * *

Many physicians have hitherto regarded only with casual interest the controversy over the organization of medical practice in this country. I, myself, for example, have assumed that a faculty member of the staff of a teaching hospital could be little affected by any of the bruited changes—a notion that has been sharply challenged by observations of the current status of physicians in this and other categories in Great Britain. Severely jarred in my complacency by what I have seen during a recent period of work on one of the active services of a large English hospital, I am recording what are admittedly only a series of impressions rather than a careful statistical study. British physicians in all types of work have been profoundly affected by the legislation of His Majesty's Government, and we here would do well to realize that none of us are necessarily immune to the consequence of radical departures in medical administrative procedure.

The latest of the items of legislation governing medical practice in Great Britain finally came into force on July 5, 1948. It is important to recognize, however, that this is only the culminating step in a series of laws that began with the National Health Insurance Act, starting in 1912. This initial legislation set up a system of compulsory health insurance for nearly all wage earners and resulted in the provision of the services of a general practitioner and of the medicines he prescribed for approximately a third of the population. No care of a medical specialist and no hospitalization were included in this measure. The Local Government Act of 1929 increased the number of hospital beds operated by the Government, and the Voluntary Hospitals Paying Patient Act of 1936 opened these institutions to the entire population whether able to pay or not. During World War II the bombing of civilians and large cities led to the construction by the British Government of numerous hospitals outside the cities and the employment either part time or full time of nearly all the physicians remaining outside the armed forces. The doctors were utilized in, and the hospitals were operated by, the British Emergency Medical Service under the Minister of Health. In addition to this organization the Ministry of Health during the war contributed notable financial support to the so-called voluntary or privately operated and endowed hospitals of the country, which included the major teaching hospitals of the medical schools. The wartime level of taxation and the rising costs of living made it apparent to all during the war that there would be insufficient voluntary donors to support the privately endowed hospitals after the war and that a major reorganization of the conditions of medical practice would be needed. Conferences between the medical profession and the Minister of Health in Mr. Winston Churchill's Coalition Government resulted in tentative agreement for the provision under the auspices of the Minister of Health of a service to cover all aspects of medical care for almost the whole nation.

The general election of 1945 placed the Labour Party in power, and this agreement was ostensibly scrapped by the new minister of health, Mr. Aneurin Bevan. He announced that he would present a measure to Parliament without bothering to have full discussion with any representative of the British Medical Association, and the dispute with the British medical profession that resulted has received wide publicity. It was a foregone conclusion, however, even three and a half years ago before Mr. Bevan took over, that the central government would be in control of the conditions of medical practice. All the major hospitals have continued to receive indispensable financial support from the Government since the war, the use of this money being subject to continuous governmental surveillance. By virtue of these facts the conditions under which consultant practice is carried on in hospitals have been but little changed since the latest act became operative on July 5. Hence

this is not a premature point at which to judge the status of the physician and his hospital work in England. Further, since the general practitioner's type of panel practice for the past thirty-six years on over a third of the population was already extended during World War II to over half the population, one may extend these accumulated data to help in analyzing his present situation with almost the whole nation on some panel.

As was to be expected there were temporary dislocations and points of stress after medical care became completely free on July 5, but no mention has been made of these in the ensuing comments. The attempt has been to refer only to facts pertinent to the long-range trends. Some of the problems that have arisen are a consequence of current shortages and Government regulations in fields other than those strictly medical; these appear to present a more chronic, self-perpetuating source of trouble and are noted below.

The effects of the British National Health Service may be considered first from the standpoint of the general practitioner and secondly from that of the specialist, or consultant, as he is termed in England.

THE FAMILY DOCTOR

The physician in general practice in England today is swamped by a volume of work that makes it possible for him only rarely to take a clinical history or make a thorough physical examination in the fashion that is attempted in this country. According to computations based on the experience with panel practice before the war, one may estimate that the British general practitioner must now in the course of a single day see in his office and in visits to homes an average of at least 50 patients if he has the average panel of 2000 persons—or 100 patients if he has the maximum panel of 4000. These figures are based on the knowledge that the prewar panel patients, largely men, each averaged five visits a year to their physicians[1] and on actuarial statistics[2, 3] that demonstrate almost twice the morbidity in women who (as well as the men) are now insured in Great Britain. Such a staggering load permits the physicians but a few minutes with each patient. The tentative impression is that this expected volume of work is actually exceeded at present.

There is 1 physician per 875 inhabitants in Great Britain[4] as compared with about 1 per 720[5] in this country. The load in England appears to arise not from a great shortage of physicians there but because the physician is expected to carry out many functions that Americans would not consider a part of his task. Many people with minor complaints—inconsequential gastrointestinal upsets and upper respiratory infections—present themselves. Even though they may recognize the triviality of the disorder, they often wish to obtain medication, which is provided free of charge with the doctor's prescription, so that they sit about in his office and wait for a handout. This availability of free conversation with the doctor and free medicine also is considered to multiply the number of mild psychoneurotic and hypochondriac patients who appear.

The Labour Government's innumerable restrictions on the lives of every person also result in countless daily appeals to the doctor for escape. The employee may not be absent from work without a valid excuse, and a note from the physician is the easiest kind of justification to present. The worker tells his doctor that he has had diarrhea for two or three days and has not been at work, and the doctor signs a form he has ready for the occasion certifying to the man's illness. This has become such a standard practice that physicians have incurred the contempt of many employers, but the unhappy physician between the fires of labor and management will naturally accede to the laborer's wish. Otherwise, the patient may request a house visit the next time and present the doctor with the evidence for his complaint if it is bona fide, or he may change his name and with it his capitation fee per annum to another physician's list. And since labor is able to outvote management, the doctor's plight is likely to worsen rather than improve if he does not play this game. Many people who wish to evade the food-rationing restrictions seek a doctor's certificate of medical need for more eggs, meat, cheese, milk and so forth. There appears to be a limitless type of such requests for special housing, heating, transportation, domestic equipment and so on *ad infinitum*. The building of an additional room on a house, the purchase of more fuel, or more electric heat, the ownership of a car or more gasoline for it—even the buying of a hot water bottle—require governmental permits, or are facilitated by governmental priorities, one avenue to which is a physician's certificate of medical need. Another group of cases in which the doctor acts more as a referee than as a healer is the workmen's compensation group. Although that exists in this country, too, there is a special feature in Great Britain that tends to make the workman dissatisfied: since the state and not he himself pays the doctor's bill, he is likely to regard the physician not as his advocate in the dispute but as that of the state from which he is attemping to wrest more money. There is virtually no neutral body of medical men that is employed neither full time nor part time by the state from whom he can secure an opinion unbiased by such employment, so that he may seek the opinions of many doctors, finally

utilizing the report of the one who would give him the most. There is still another group, the war veterans, over whose demands for special funds the physicians in Great Britain must act as umpire. The war veteran in this country is entitled to compensation for any medical disability he may develop, only if he is unable to pay for the treatment himself, but the British veteran is so favored only if the disability arose as a direct consequence of his war service. The burden of testifying to this thorny problem falls on the doctor.

Another handicap imposed on the general practitioner is the extreme paucity of special diagnostic facilities at his command. Even routine blood counts are difficult for him to obtain—not to mention quantitative blood chemical analyses and bacteriologic or roentgenographic studies. Almost the only clinicopathological and x-ray departments are those in hospitals, and these are already swamped with work from the hospital itself. The directors of these departments suspect, doubtless rightly, that if the general practitioner were able to call on them at will, many would abuse the privilege, writing out the requests for laboratory work with the same lavish hand that dispenses excuses for absenteeism. The conscientious student of his cases thus has his ardor dampened by the fact that as soon as a patient with an interesting problem appears he must refer that person to a consultant.

The Labour Government announces that it is proposing to set up so-called health centers in which several doctors will have their offices and at which there will be a diagnostic laboratory. No such centers have yet been built, nor are any being projected for the immediate future. It is pertinent to contrast this situation with the type of practice so prevalent in this country for some decades in which groups of doctors have organized themselves on their own initiative to provide not only laboratory but also roentgenologic studies for their patients, along with specialized consultant services within the group.

The fact that house calls are now free in Great Britain removes one useful restraint from the type of patient who nurses his complaints in silence all day and then decides at midnight that he had better call a doctor. Failure of a physician to answer an emergency call not only may unfairly lose him the patronage of the patient but also is the basis for serious disciplinary action by the General Medical Council or other appropriate agency. One painstaking physician, fearful lest a real emergency be overlooked, has become so exhausted and distraught answering futile night calls that a psychiatrist has had to recommend a protracted period of vacation.

The so-called patient's free care extends to the dispensing of such needed appliances as braces and eyeglasses. He tries in the first instance to get from the general practitioner whatever arch supports or girdles may appear a handy thing to have about. But if the patient is balked at this level the opinion of a consultant may be demanded. In an outpatient clinic in which I was working a man appeared with an excellent result following the removal through a small laminectomy of a midthoracic cord tumor. He put on a little show for us in an effort to get a back brace, making it clear that he thought he was now entitled to this, and meant to have it. A further consequence of the fact that the Government is now the only purchaser of prostheses and braces is the driving out of business of all firms that the Minister of Health does not see fit to support. The doctor may order an appliance for his Health Service patient but he may not designate the firm that is to make it. This proscription is, for example, eliminating from the field one firm that is widely regarded as the best British maker of artificial limbs but is no favorite of the Labour Government.

THE CONSULTANT

And what of the lot of the consultant group? In 1945 a distinguished man in this category told me what striking improvements the reorganization would bring. For the first time the men in training would be paid adequately, and there would be enough of them to relieve the senior staff of onerous duties. The systematic planned utilization of the available personnel for the whole country could only lead to greater efficiency; necessary improvements would have only to be pointed out to the Minister of Health or his representative with direct access to the nation's Treasury and need not depend on the caprice of private gifts as it had before the war. Each major medical school would be the center of a region of the nation with its regional medical board, exercising a salutary continuing influence over the actual medical practice of the area long after the physician had finished his postgraduate training in the hospital.

Three years later the same consultant, now recognized as the most outstanding member of the medical faculty of his university, is like his colleagues working under many handicaps. His eminence led his university in 1944 to promise him an institute, to be erected forthwith as three temporary one-story buildings without basement, on empty space already available in the hospital grounds. By 1948 one of these has barely started; the other two are less than half finished. Yet this is virtually the only hospital construction under way since the war in a city of a million inhabitants. The details of the numberless delays, which have already dragged out to over four years a construction that should have been

a four-month task, furnish a monotonous account of the hamstringing of every energetic person by the requirement of a governmental permit for every item of material, for all the precursors of each of the materials, for the transportation of the precursors and the materials, for the allocation of the appropriate type of labor to handle the precursors of the materials, the materials and their actual construction and so on *ad nauseam*. These appear to be the advantages of completely centralized integrated control so that first things can be done first. The activities of the most distinguished worker in this hospital continue to be carried on with the same primitive facilities that burden the remainder of the staff. All this is despite the fact that the Minister of Health has been for years in charge of all housing as well as hospital construction and might reasonably have been expected to provide for a little work on hospitals.

It is perhaps pertinent at this point to draw attention to the exclusive power of the Minister of Health under the present act to appoint all members of all medical boards governing all aspects of medical practice in the whole country, including the teaching hospitals. There is no grant *en bloc* of funds to units that otherwise remain independent of the Government, such as occurs now in relations between United States federal agencies and research groups, and represents the British method of support of its universities (entirely apart from the medical schools). Under a system in which the autonomy of the local group is preserved, tasks might well be completed in a reasonable time instead of dragging on in such a preposterous fashion for years.

The paucity of men of consultant status, serious before the war in England, has not been alleviated, despite the fact that increasing knowledge makes the need for them greater. The waiting list on the neurosurgical service on which I worked was such that a patient with a presumed brain tumor had to wait about three months before he could enter the hospital. Numbers die before they reach the top of the list. There was virtually no time available to operate for the relief of pain on patients with malignant neoplasms—no matter how good their prognosis for a long useful life if free of pain.

The volume of nonmedical duties falling to the consultant, although not so overwhelming as that of the general practitioner, is still oppressive because all the factors creating such duties operate on him as well, albeit to a lesser degree. In the Regional Medical Board meetings the agenda drawn to my attention were largely cluttered with items of minor business administration, such as approving a new heating plant for an outlying hospital. To these the most senior and capable medical members of the community found themselves compelled to devote whole afternoons. I am told that they dare not resign from these boards, though, lest control be gained by men who would make the practice of medicine a series of acts of obedience to such fiats, proclamations, directives and commands as the board might see fit to dispense.

A minor example of the advantages of bureaucracy was my experience of applying to the appropriate segment of the Ministry of Health in Whitehall for certain special instruments to perform an operation by a hitherto untried method. The whole project was explained in some detail, and the letter of request received a prompt postal reply promising consideration. Eight months later, long after I had obtained the needed articles from a private source, I had a letter declining the request because the instruments were not part of the usual neurosurgical setup.

One should mention that men in hospital training for consultant posts are to be paid salaries after the internship period that are somewhat higher than those paid by the major teaching hospitals in this country. The financial support at this crucial period in a young man's life permits merit to be a more significant factor in determining selection for advanced training and is a feature of the British system that might well be emulated in this country.

No systematic discussion of salaries to be paid to the various categories of practicing physicians will be attempted here; final decision regarding the salary scales for consultants has not even been made although the profession has been at work since July 5 under the new regime. However, the present salaries of three colleagues and personal friends bear mention. They are consultants with extended complete postgraduate training in a surgical specialty, and they now hold full-time appointments in major hospitals. Each of these men with a family is paid about $2500 per year after income tax deductions, and this is a representative income for such men under forty years of age throughout England. This permits each a scale of living approximately similar to that which one would obtain in this country on such an income, but the startling fact is the relation of this annual earning to that of other groups in the country. It is indeed a smaller yearly income than that of a skilled mechanic in England working far less "overtime" than these men do. Every one of the skilled laborers in a factory of the father of one of these men has a higher income than he does after his fifteen years of higher education and postgraduate training and experience. The one man of the three who has no familial or other outside source of financial assistance cannot, of course, even afford to own a car. Two of the three men are actively exploring possibilities for

leaving the country. One finds it difficult to avoid the impression that the medical profession in England is being burdened beyond the limit of tolerance.

THE PROBLEM

On the basis of the foregoing statements representing a catalogue of acts checked since the writing of this article by four different English physicians now in this country, a personal opinion will be ventured on the significance of these facts to the medical profession in the United States. In the first place, the sorry plight of our British colleagues appears to be due to their having been compelled to accept terms imposed by nonmedical members of the nation. Had they analyzed the defects in their system, presented a well conceived plan for improvements, and then stood fast against ill advised changes, the British people might now be receiving better care and the physicians might be happier about their working milieu. American physicians are or should be more familiar with the shortcomings in the present scheme here than anyone else. Unless they come up with a constructive program correcting these faults—perhaps even if they do—they can expect outside imposition of laws that, the British experience suggests, will at least in some aspects be detrimental to the best interests of the patient and his doctor.

The purpose of this article will be grossly misconstrued if it is considered an argument against any change in the present organization. The thesis is, on the contrary, that changes must occur and that the problem should be analyzed and the most logical type of reorganization effected.

One crucial feature of the difficulty in England, I believe, is that the responsibility for being healthy and economically self-sufficient has been shifted from the patient to his physician. I wish that the medical profession knew enough about human personality in health and disease to shoulder this responsibility, but I am convinced that I at least do not. When the political order in a country offers a helping hand to its ill citizens to assist them to struggle to their economic feet, the main burden of recovery should still fall on the patient. All physicians have seen striking examples of protracted convalescences that were being paid for by someone else, in contrast with brisk returns to activity in patients with the same disorder who were determined to lead active lives again at the earliest moment.

There are three groups of cases in which the physician is at a peculiar disadvantage when the patient sheds the responsibility for getting well. In the first of these the person with a purely psychologic or simulated disorder is thought to have organic disease. In a manuscript currently in preparation I am including the case of a nurse who described in herself the symptoms of trigeminal neuralgia sufficiently graphically so that in five different major teaching hospitals she had a total of three alcohol injections and two operations on the trigeminal pathways, and yet after scores of hours of study by several examiners her physicians are still uncertain whether she ever had trigeminal neuralgia. This represents one of many organic disorders—for example, migraine, angina pectoris and other neuralgia—in which no objective signs of abnormality are necessarily present, and by virtue of which the patient without the disorder may consciously or unconsciously delude the physician with a convincing description.

The converse situation, in which an organic disorder is diagnosed as psychoneurosis by the physician, is also seen with disconcerting frequency. During the war I eventually saw several men whose presenting symptoms of their intracranial tumors were much more suggestive to their original medical officers of an inordinate desire to avoid combat than of any organic disease. One of the most unattractive features of medical practice in the armed forces is the frequent necessity of distinguishing the sick from those who complain of illness to avoid duty. The inefficient means for grappling with this problem is one of the causes for such a disproportionately large need for medical officers in the armed forces.

But the most difficult group of all is the much larger one of the patients with unequivocal evidence of structural malady in whom the question arises whether the complaints are excessive for the degree of anatomic damage present. How can the doctor, who unfortunately cannot feel the patient's pain, tell whether the headache that allegedly persists after a fracture of the skull or a back that goes on aching after a protruded intervertebral disk is removed should be treated by a prompt return to work or some financially compensable and less arduous tactic? I fear that even after hours of patient effort one emerges only with a guess.

In the present state of ignorance, if the doctor is to keep the good will of the community and his own self respect, he must do his best to see that his duties are so delineated, and the society so organized, that the number of cases in the foregoing three categories will be kept to a minimum. As soon as the political order or any other environmental feature makes it advantageous for any citizens to present themselves with medical complaints, a discouraging additional number of them can apparently be counted on to do so. If the task of assessing the ability to lead an active life and the compensability of lack of enthusiasm therefore is to be extended to the entire population, the

experience in Great Britain suggests that in this country extended ill feeling between the medical profession and other segments of the nation and a deterioration in the quality of medical care can be anticipated.

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3. Watson, A. W.: Analysis of Sickness Experience. J. Inst. Actuaries 62:(Part I) 12-61, 1931.
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5. Dickinson, F.: Personal Communication.

A. M. A. Has No Official Spokesman Editorial States

The American Medical Association has not now and never has had an official spokesman, points out an editorial appearing in the March 19 issue of *The Journal of the American Medical Association.*

Following are excerpts from the editorial:

"No committee, council, board, officer, or employee of the association is charged with establishing policies for the American Medical Association. The association has not now and never has had an official spokesman.

"All officials of the association, including the president, the president-elect, the secretary, and the chairman of the Board of Trustees, make public appearances and are interviewed. When they speak, they endeavor to interpret the policies of the House of Delegates. The employees of the association, including the general manager, the editor, the secretaries of the various councils and committees, and the directors of the bureaus, also make many public appearances; when they speak or when they are interviewed, they also present the policies adopted by the House of Delegates.

"Recently the association has established a division of public relations and has employed special public relations counsel in connection with a program of education of the American people regarding the present status of medical care and the proposals that have been made for extension of medical care. These agencies represent the American Medical Association. When they issue releases to the press or make public pronouncements, as they frequently do in delivering addresses, they also present the point of view of the House of Delegates.

"The statements here made are intended to correct unwarranted misrepresentations to the association.

"Until the House of Delegates acts to change a decision, every council, bureau, officer, and employee is bound by the prevailing actions of the House of Delegates."

A. M. A. Provides $25,000 for Chronic Illness Commission

Carrying out another of the objectives of the American Medical Association's 12-point program for the advancement of medicine and public health, the Board of Trustees of the A. M. A. has made available $25,000 to set up the Commission on Chronic Illness.

The sum, drawn from the A. M. A.'s national education campaign fund, was allotted to the Interim Commission on Chronic Illness, which will set up the permanent commission. The A. M. A. has also provided office space at its Chicago headquarters to the permanent commission, representing voluntary agencies, government agencies, and the public.

Purpose of the commission will be to promote programs for the control of chronic illness in every state.

The commission is a joint project of the A. M. A., the American Hospital Association, the American Public Health Association, and the American Public Welfare Association, and was recommended by the Section on Chronic Disease of the National Health Assembly. Dr. James R. Miller, Hartford, Conn., member of the Board of Trustees of the A. M. A., is chairman of the Interim Commission and will be a member of the permanent commission.

Proposed activities of the permanent commission are:

1. To assemble existing data in order to evaluate and make use of all that is now available and to determine areas requiring further study.
2. To serve as a clearing house for information on laws, programs, experiments, and new developments; to keep all interested groups informed through a newsletter published regularly; and to publish special reports from time to time.
3. To stimulate the development of new methods and techniques in the organization and administration of services for the chronically ill.
4. To develop suggested patterns for integrated community programs.
5. To establish criteria for the appraisal of state and local chronic disease programs and facilities.
6. To give consultation to private and public state, regional, and local agencies interested in planning for the chronically ill.
7. To suggest a priorities for the determination of immediate as against long range needs for the guidance of state and local communities.
8. To explore methods of implementing the recommendations made by the commission.
9. To prepare a report to the American people outlining a comprehensive plan for the prevention and control of chronic disease and for the care and rehabilitation of the chronically ill.

Proceedings of The Council . . .

Plans for Intensified Public Relations Program in Ohio Adopted; Bills in Ohio Legislature and Congress Reviewed; Reports Received

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the Columbus Office on Sunday, February 27, 1949. All members of The Council were present except Doctors Bowman, Dixon and McAfee. Others attending the meeting were: Messrs. Nelson, Saville, Page and Moore; and Dr. Jonathan Forman, Editor of *The Journal.*

On **motion** duly made, seconded and unanimously **carried,** the minutes of the meeting of The Council held on December 12, 1948, **were approved.**

Membership statistics were reported as follows: Total membership as of February 25, 1949, 6,525; compared to a total membership of 7,331 as of December 31, 1948.

On **motion** duly made, seconded and unanimously **carried,** the Executive Secretary was authorized to collect State Association dues **for new members** for the third and fourth quarters for 1949 as follows: New members affiliating in the third quarter, $10.00; new members affiliating in the fourth quarter of the year, $7.00.

Following a general discussion on the matter of officers of the Veterans Administration affiliating with the A. M. A. as Service Fellows, on **motion** duly made, seconded and unanimously **carried,** Ohio's delegates to the A. M. A. were requested to make an investigation of the question as to whether Service Fellows would have voting rights, especially on questions which might be taken to referendum by the A. M. A.

A. M. A. PROGRAM

Dr. Brindley, Mr. Nelson and Mr. Saville reported on the A. M. A. Public Education Program Conference held in Chicago on February 12.

The Executive Secretary presented a breakdown by counties on the payment of the $25.00 A. M. A. assessment as of February 22, 1949. The matter of follow-up procedure among those who have not paid the assessment was discussed. Action was deferred pending a report on collections at the April meeting of The Council.

OHIO PLANS

Reporting for the Committee on Public Relations, Mr. Saville, Director of the Department of Public Relations, presented a series of recommendations for an intensified public relations program in Ohio to be carried on in coordination with the national educational program of the A. M. A. The report and recommendations of the Committee on Public Relations and Economics on this matter **were approved** by an unanimous vote of The Council, with the added recommendation that the recommendations for county society action be submitted in writing to the county societies by members of The Council, with an offer to appear before the county society for the purpose of discussing the program and recommendations. (See page 385 for complete report.)

Numerous legislative proposals pending in the Ohio General Assembly were reviewed and discussed and policies for or against them were adopted. The Executive Secretary was instructed to cite these actions in the legislative bulletin as the various proposals come up for a hearing or a vote.

The Council also reviewed pending Federal legislation and established policies on the Federal measures as to principle.

ENDORSED A. M. A. PLATFORM

At this point The Council, by an unanimous vote, endorsed the newly issued 12-point program of the American Medical Association and instructed the Executive Secretary to convey this information to Ohio's members of the Congress.

A report of a meeting of the Committee on Education, held in Columbus on January 23, 1949, was submitted to The Council. The report was in the nature of a progress report on plans for the fall postgraduate seminars. On **motion** duly made, seconded and unanimously **carried,** the report and suggestions of the committee **were approved** by The Council and the committee instructed to proceed with definite plans for the fall meetings. (See page 396 for complete report.)

A report on the meeting of the Committee on Cancer, held in Columbus on January 23, 1949, was submitted to The Council on behalf of that committee. The report **was approved** by an unanimous vote and the committee instructed to proceed with its plans for future activities. (See page 396 for complete report.)

Dr. Mundy, Chairman of the Committee on Rural Health, reported on a meeting of that committee held on February 20 in Columbus. The recommendations of that committee, including definite plans for an Ohio State Medical Association rural medical scholarship, **were approved** by an unanimous vote. (See page 396 for complete report.)

Dr. Worstell, chairman of the Committee on Industrial Health and Workmen's Compensation, presented a report on a meeting of that committee held on February 5 at the Columbus Office. This report was approved by The Council on **motion** duly made, seconded and unanimously **carried.** (See page 396 for complete report.)

The Executive Secretary reported that plans and arrangements had been completed for the 1949 Annual Meeting to be held in Columbus, April 19-22, inclusive; that the detailed program would be printed in the March issue of *The Journal*; and that a mailing folder on the meeting would be sent by direct mail to all members.

NEED FOR MEDICAL OFFICERS

A letter dated February 9 from Dr. George F. Lull of the American Medical Association, with respect to the need of the Armed Forces for medical officers, was read and discussed. Dr. Lull's letter was accompanied by a list of Ohio physicians who had been deferred while in training from active duty with the Armed Forces and the letter requested the Ohio State Medical Association to urge these young physicians to volunteer their services to the Armed Forces immediately. On **motion** duly made, seconded and unanimously **carried,** the Executive Secretary was instructed to make a breakdown of the names of such physicians and to send lists to the president and secretary of each county medical society of the counties in which such young physicians are located, with a request that a committee of the county society interview such physicians and urge them to volunteer for the Medical Corps of the Army, Air Force or Navy at the earliest possible date. (See page 404 for additional report.)

AID WORLD MEDICAL ASSOCIATION

A communication from Dr. Louis H. Bauer, Secretary-Treasurer of the World Medical Association, was read. The letter requested the Ohio State Medical Association to make a financial contribution to the activities and program of the World Medical Association. Also, it urged the Association to suggest to its members that they become Founder-Sustaining members of the United States Committee of that Association at an annual subscription fee of $10.00. The Council expressed itself as believing that this is a very worthwhile project and by an unanimous vote authorized the payment of a contribution to the amount of $500.00.

The Council was advised that the Association had been requested to nominate a member for the Revision Committee for the United States Pharmacopoeial Convention to be held in 1950. On **motion** duly made, seconded and unanimously **carried,** this invitation was accepted and the President was authorized to select a nominee at the appropriate time.

A communication from Dr. Elmer Hess, chairman of the Committee on Hospitals and the Practice of Medicine of the American Medical Association, was read and discussed. Dr. Hess' letter suggested that the Association appoint a special standing committee on hospital relations. The communication was filed for reference at a future date, inasmuch as many members of The Council expressed a belief that such matters could be handled at this time through The Council or by the Committee on Judicial and Professional Relations.

OHIO MEDICAL INDEMNITY

The attention of The Council was called to the annual stockholders' meeting of the Ohio Medical Indemnity, Inc., in April. There was a general discussion of nominees for the Board of Directors. On **motion** duly made, seconded and unanimously **carried,** the following individuals were authorized to cast the vote of the Ohio State Medical Association at the annual stockholders' meeting on business matters coming before that meeting: That Dr. A. A. Brindley, President, or Dr. C. C. Sherburne, or Mr. Charles S. Nelson be authorized to vote the shares of the Ohio State Medical Association.

Dr. Clodfelter, reporting for the Advisory Committee to the Womans' Auxiliary, suggested to The Council that it make a contribution of $300.00 to the Auxiliary to assist it in meeting current expenses between now and the collection of increased Auxiliary dues. On **motion** duly made, seconded and unanimously **carried,** an appropriation to the Auxiliary in the amount of $300.00 was authorized.

HEART PROGRAM DISCUSSED

There was a general discussion of the publicity program of the Central Ohio Heart Association. A number of communications from members and county medical societies with respect to statements made in the publicity of that Association, offering free electrocardiograph examinations to the public generally, were read. The Executive Secretary was instructed to communicate with the officials of that Association to secure complete information as to how the funds now being collected will be spent and on the contemplated activities of the organization so that The Council would be in a position to take action, if necessary, at its next meeting.

At this point the question was raised on the matter of medical and health clinics offering services to the public generally, especially as to whether such clinics should or should not make a charge for their services. On **motion** duly made, seconded and unanimously **carried,**

this question was referred for study and a report to the Committee on Public Relations and Economics.

MISCELLANEOUS ACTIONS

A communication from the Tennessee State Medical Association, requesting this Association to support the recommendations of the Committee on Veterans Affairs of the American Medical Association with respect to changes in the operation of the medical services of the Veterans Administration, was read and discussed. It was ordered filed for future consideration.

The Executive Secretary reported that a communication had been received from the Veterans Administration suggesting certain changes in the medical and surgical fee schedule. This question was referred to the Committee on Medical Care of Veterans for review and for a report to The Council at its meeting on April 18.

A communication, asking for a contribution to the United Negro College Fund, Inc., was read. The Council expressed sympathy with the movement but felt that the Association could not make a contribution at this time.

A communication from Dr. David J. Roberts, President of the Summit County Medical Society, was read and ordered filed. This communication complimented the special committee of The Council, which had acted as a referee in a controversy between the Summit County Medical Society and the Akron Children's Hospital and which controversy has been settled to the satisfaction of all parties.

There being no further business, The Council adjourned to meet on Monday evening, April 18, 6:00 p. m., in Private Dining Room No. 4, Neil House, Columbus, Ohio.

Attest: CHARLES S. NELSON,
Executive Secretary.

Cleveland Academy, Bureau Pioneer In Banning Rebates

The Academy of Medicine of Cleveland and the Cleveland Better Business Bureau have pioneered in a successful attempt to abolish the practice of rebating by opticians and firms dispensing eye glasses and other optical aids.

Thirty-three opticians and optical firms initially signed the "Optical Dispensing Code" which went into effect in February under the administration of the Cleveland Better Business Bureau. Chief point in the new standards, according to an article appearing in the *Bulletin of the Academy of Medicine of Cleveland*, is a pledge that there will be no secret rebates to doctors who prescribe glasses for patients.

As a result of the part played by the Academy in helping to work out the agreement, the Bureau is now operating a Professional Division, one of whose functions is the administration of the new Code, the *Bulletin* stated.

ROUNDUP ON PREPAID MEDICAL CARE PLANS

Newly elected Blue Shield Commission, governing body of Associated Medical Care Plans, meeting in Chicago, January 15-16, re-elected Dr. L. Howard Schriver, Cincinnati, president for his third term. Dr. Robert L. Novy, Detroit, was elected vice-president. Returned also as officers were Dr. Norman M. Scott, Newark, N. J., as secretary, and Mr. Jay C. Ketchum, Detroit, as treasurer.

* * *

Prepayment plans for medical care are being established in several new areas throughout the United States, rapidly approaching the point where it can be said that medically sponsored plans are available in every community.

Arkansas—Medical and Hospital Service, admitted to membership in A. M. C. P. during January and the youngest Blue Shield Plan in America, was incorporated in December.

Connecticut—Sponsorship of Connecticut Medical Service was approved by the House of Delegates in that state at a special meeting in December.

Illinois—In January two new charters were issued by the State under the special enabling act for establishment of prepayment medical care plans in Rockford and Rock Island.

Kentucky—Incorporation papers for Kentucky Physicians' Service, at last report, were ready for filing by the incorporators elected by the Kentucky State Medical Association.

Tennessee—A surgical plan was undertaken by Blue Cross in Memphis early in December and is operating at the present time without any direct relationship with the medical profession. During December physicians in Chattanooga formerly requested the Blue Cross Plan to organize a prepayment surgical plan.

* * *

Ohio Medical Indemnity, Inc., (the Ohio Doctors' Plan) on February 28 had contracts covering 483,859 persons. This was an increase of 10,840 additional persons covered during the month of February.

* * *

On February 2, California Physicians' Service observed its tenth anniversary, having been the first state-wide prepayment plan to be organized by the medical profession. C. P. S. is the fourth largest Blue Shield Plan in the United States, having enrolled 699,998 persons on December 31, being surpassed only by Blue Shield Plans in Michigan and New York City, which are over the million mark.

Ohio's Public Relations Plan . . .

Action Taken By Council on February 27 Outlining Activities of State Association and Suggestions for County Societies and All Physicians

A PLAN of action to step up the public relations activities of the Ohio State Medical Association and to coordinate them with the National Education Campaign of the American Medical Association was adopted by the Committee on Public Relations of the State Association at its meeting on February 6 and approved by The Council at a meeting on February 27.

The general strategy, major issues and fundamental procedures of the A. M. A. campaign were fully outlined during a meeting of State Medical Society leaders with A. M. A. representatives and Whitaker and Baxter, campaign directors, at a meeting in Chicago, February 12. At that meeting it was announced that the campaign had two major objectives:

The immediate objective is the defeat of the compulsory health insurance program pending in Congress.

The long-term objective is to put a permanent stop to the agitation for compulsory health insurance, the most vital step in achieving this objective to be an all-out campaign to enroll the American people in voluntary health insurance systems and to put into effect the activities enumerated in the new A. M. A. 12-Point Health Program.

Over-all responsibility for the conduct of the campaign is in the hands of the Coordinating Committee of the American Medical Association, headed by Dr. Elmer E. Henderson, Chairman of the Board of Trustees. The Campaign Directors are responsible to the Coordinating Committee, and the Coordinating Committee is responsible to the House of Delegates.

A. M. A. PLANS

The job at National Campaign Headquarters breaks down as follows:

1. Development and direction of national planning and campaign strategy.

2. Direction of the National publicity campaign, utilizing, largely, the existing normal channels—the press associations, major newspapers, radio networks and television, the national magazines, trade publications, news letters, etc.

3. Direction of the national-organization endorsement drive, designed to mobilize hundreds of national organizations in support of medicine's cause.

4. National coordination of the work in the 48 states, the District of Columbia and the several territories.

5. Production of all basic campaign literature and materials, including posters, pamphlets, leaflets, reprints, form resolutions and speeches, cartoons and mats, publicity which can be adapted for State use, lists of organizations, conventions, etc. Press runs of pamphlets and other materials are expected to total 100 million copies during the first twelve months of the campaign.

6. Organization and direction of a National Speakers' Bureau to cover top-assignment speaking engagements.

7. Direction of a National Women's campaign, geared to bring support of the major women's organizations and to arouse women throughout the Nation to the threat of socialized medicine.

8. Active cooperation with the prepaid medical and hospital plans and the accident and health insurance companies in an all-out drive to provide the American people with voluntary health insurance coverage. Special literature will be produced for use of the voluntary systems, and the A. M. A. campaign will be closely meshed with the promotional work of the Blue Shield, Blue Cross and private insurance companies.

In order to effect maximum utilization of the techniques and ammunition prepared by the National Campaign Headquarters of the American Medical Association, and to supplement existing public relations activities of the Ohio State Medical Association, The Council on February 27 approved the following program of action for the Ohio State Medical Association, the county medical societies, and for individual physicians:

OHIO STATE MEDICAL ASSOCIATION

1. Formation of an inter-organization committee of representatives of state-wide business, industrial, farm and professional organizations, to which the ramifications of the Truman-Ewing National Health Program will be explained and the public's stake in the proposal emphasized. It is anticipated that this committee will prove a powerful ally in the campaign.

2. To set up an enlarged Public Relations Committee, consisting of the present committee and selected physicians from throughout the state. Qualifications include alertness, vision, influence and willingness to work.

3. Form a state-wide Public Relations Speak-

ers' Bureau. The principal function of this bureau will be to furnish speakers when "out-of-town" talent is requested. It would include physicians and laymen as speakers.

4. Supply packages of reference material on the issue of compulsory health insurance to every public, college and school library in the state.

5. Produce additional literature to supplement that furnished by the A. M. A. for distribution to the public through doctor's offices and at public meetings.

POSITIVE CONSTRUCTIVE PROJECTS

The affirmative, constructive public relations program of the Ohio State Medical Association which has developed rapidly in the past few years will be stepped up. That program is based on the premise that every activity of the Association, either directly or indirectly, affects the public relations of medicine, and that anything the Association can do as an organization and through its members to give the public better medical service will be reflected in improved public good will toward the medical profession.

These activities include:

1. The promotion of Ohio Medical Indemnity, Inc.

2. Constructive programs of such committees as rural health, school health, cancer, mental hygiene, industrial health, etc.

3. Professional guidance to various governmental and private agencies.

4. Sponsorship of sound legislation in furtherance of the 25-point Health Program for Ohio.

5. The Placement Bureau, which steered about 50 physicians into areas in Ohio needing doctors last year.

6. Press and radio releases and contacts.

7. Exhibits and distribution of health education materials at meetings of health and welfare organizations.

The foregoing does not contemplate any let-up in the Association's program for the scientific education of its members through the Annual Meeting, postgraduate programs and *The Ohio State Medical Journal*, the Speakers' Bureau for county medical society meetings, all of which represents an important activity of the Association which is very definitely in the public interest.

COUNTY MEDICAL SOCIETY FUNCTIONS

1. Each county medical society must have an active public relations committee, composed of vigorous, well-informed physicians of high standing and influence in the community.

2. A county speakers' bureau should be formed, and the message of the medical profession taken to every luncheon club and civic organization in the county. The speakers will be provided with source material, prepared talks and outlines from the American Medical Association and the Ohio State Medical Association.

3. An effective plan must be worked out by the society for the handling of emergency calls, night calls and calls on the doctors' afternoon off.

4. Some kind of mechanism must be established for the arbitration of complaints about fees and misunderstandings between physician and patient.

5. A more aggressive, constructive role must be assumed by the society in meeting community health problems, perhaps using the O. S. M. A. 25-point health program as a guide.

6. Either through a special Press and Radio Committee or the Committee on Public Relations, proper contacts should be made with the local newspapers and radio stations, so that their facilities can be fully utilized in keeping the public advised of the activities of the society in the public interest.

7. Each county medical society which does not now have a Woman's Auxiliary should establish one promptly, and see that the auxiliary is given specific assignments in the county society's public relations program.

8. A county-wide meeting of representatives of farm, business, industrial and professional organizations should be sponsored by the county society, similar to the state-wide meeting being arranged by the State Association.

9. One program of each county medical society should be devoted solely to public relations and legislation, at which a strong resolution should be adopted advocating the voluntary and opposing the compulsory approach to better health for the American people.

PRACTICING PHYSICIAN'S ROLE

1. The practicing physician must be especially considerate of his patients as to fees, general office procedures, keeping of appointments, collection methods, handling of night and emergency calls. His receptionist should be instructed accordingly. The booklet "Date with the Doctor" should be her primer.

2. He must be more willing to accept his responsibility as a citizen in community affairs.

3. He should take every opportunity in his daily practice to point out astutely to his patients, why—in the patient's interest—he is opposed to socialized medicine.

4. He should make a special effort to advise his patients of the desirability of voluntary insurance programs, such as Blue Cross and Blue Shield—in Ohio, "The Doctors' Plan—Ohio Medical Indemnity, Inc.

5. His waiting room should have an abundance of pamphlets and other campaign material

furnished by the State Association and the American Medical Association.

6. He should analyze his contacts with patients and give county society officials the names of influential patients that he believes can be helpful in the society's public relations program.

The plan of action of the Ohio State Medical Association, and suggestions for public relations activities by the county medical societies and individual physicians will be published in detail in the near future in a booklet to be distributed to county medical society officers and public relations committeemen.

Mahoning Postgraduate Day Scheduled April 13

The Mahoning County Medical Society will hold its 21st Annual Postgraduate Day on April 13 in the Pick-Ohio Hotel, Youngstown, beginning at 9:30 a. m.

The faculty will be composed principally of four men from the University of Buffalo College of Medicine. They are Dr. John R. Paine, professor of surgery; Dr. John H. Talbott, professor of medicine; Dr. Roswell Brown, associate professor of surgery, and Dr. Earl Osborne, professor of dermatology and syphilology.

Two morning clinics will be held—a surgical clinic at St. Elizabeth's Hospital Nursing School, and a medical clinic at Stambaugh Nurses' Home, Youngstown Hospital.

Dinner will be held at 6:30 p. m., followed by a round-table discussion.

Cerebral Palsy Center

Reportedly the first cerebral palsy center of its kind in the nation will be opened next fall at Bowling Green State University, according to officials of the university and the Ohio Society for Crippled Children, co-sponsors of the project.

Children from all parts of Ohio will be considered for enrollment. The university will provide supervisory personnel, quarters, testing equipment now on hand, etc. The Ohio Society will provide professional personnel and specialized equipment.

Dr. Ralph W. Holmes, Chillicothe, chairman of the Society's professional advisory committee on cerebral palsy, is on the center's planning committee.

Foundation Prize

The South Atlantic Association of Obstetricians and Gynecologists announced the establishment of "The Foundation Prize." Authors of papers on obstetrical or gynecological subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, secretary-treasurer, 1259 Clifton Rd., N. E., Atlanta, Ga.

Veterans Administration

Veterans Administration officials recently announced that orders had been issued eliminating the 13 Branch Offices, including Branch No. 6 at Columbus, and establishing in these locations 13 District Offices which will be limited to operational activities involved in handling National Service Life Insurance and death claims.

This means that all supervision of field offices which has heretofore been carried on by the 13 Branches will now be directed from the central office in Washington.

As far as the relationship between Ohio doctors and the Veterans Administration is concerned, elimination of the branch in Columbus is merely an administrative change, Dr. Peter A. Volpe, who has been medical director for the Columbus Branch Office, said. The contract between the Ohio State Medical Association and the Veterans Administration will continue as in the past. Since doctors' contacts with the V. A. are made through regional and sub-regional offices, the change will not be felt by the medical profession. Elimination of the branch offices is expected to be completely effected by June or July.

Branch No. 6 had jurisdiction over V. A. affairs in Ohio, Michigan and Kentucky. Regional offices are located in Cleveland and Cincinnati and sub-regional offices, strategically located throughout the State, operate under these two regional offices.

According to an announcement from V. A. Administrator Carl R. Gray, Jr., "managers of Regional Offices, Hospitals and Centers shall be responsible to the Administrator . . ."

* * *

Acquisition of the 1,000-bed U. S. Naval Hospital at Houston, Texas, by the Veterans Administration and cancellation of V. A. plans to construct a 1,000-bed neuropsychiatric hospital, also at Houston, were announced by Carl R. Gray, Jr., administrator of veterans affairs.

Transfer of the Naval hospital will result in a savings of $21,000,000 in construction costs. Mr. Gray pointed out that the action, which was authorized by the President, is in the interest of more effective utilization of Federal hospital facilities and will avoid operation of two large neuropsychiatric hospitals side by side in the same community. It will also enable the Veterans Administration to meet its critical needs for neuropsychiatric beds in the Houston area two years earlier.

A new journal, *Fertility and Sterility*, to be sponsored by the American Society for the Study of Sterility, is scheduled to begin publication soon by Paul B. Hoeber, Inc., 49 E. 33rd St., New York 16.

Annual Meeting Speakers . . .

Eleven Guest Lecturers Will Be Among Nearly 250 Outstanding Doctors To Take Part in Scientific Sessions at Columbus Convention, April 19-22

BY far the largest faculty of medical instructors, lecturers and discussants ever assembled for an annual session of the Ohio State Medical Association will take part in the **1949 Annual Meeting, April 19, 20, 21 and 22, at the Neil House and Deshler-Wallick Hotel, Columbus.**

Among approximately 250 doctors of medicine on the program, will be 11 guest speakers from other states, each of whom is nationally known in his field.

Limited facilities will place a maximum on the number of persons who can attend most of the Instructional Courses. Admittance therefore will be by ticket for which there is no fee. Those interested in attending these courses should return the card mailed to each member several weeks ago. There will be ample space at the other scientific sessions.

The number who may attend the Annual Banquet on Wednesday evening, April 20, also is limited. Those who have not already done so should make reservations at once. Tickets for the banquet will cost $5.50 each.

Following are brief biographical sketches of the guest speakers who are scheduled on the program:

Kenneth E. Appel, M. D., Philadelphia, Pa., is professor of psychiatry, University of Pennsylvania School of Medicine, and director of the Clinic for Functional Diseases, Hospital of the University of Pennsylvania. He received his degree from Harvard Medical School in 1924; is a member of the Association for Research in Nervous and Mental Diseases, and the American Board of Psychiatry and Neurology, and is on the Executive Committee of Counsel of American Psychiatric Association. Dr. Appel will speak on "Psychiatric Aspects of Medicine," at 3:35 p. m., Thursday, in the Main Ballroom of the Neil House.

Charles S. Cameron, M. D., New York City, is medical and scientific director of the American Cancer Society and assistant attending surgeon at Memorial Hospital in New York. He is a graduate of the Hahnemann Medical College, 1935. In addition to his official capacity in the American Cancer Society, he is a member of the James Ewing Society and the American College of Surgeons. Dr. Cameron will speak on "Cancer Control" at 3:35 p. m., Tuesday, in the Main Ballroom of the Neil House.

A. C. Furstenberg, M. D., Ann Arbor, Mich., is dean of the University of Michigan Medical School and professor of Otolaryngology; is a member of the American Academy of Ophthalmology and Otolaryngology, the American Laryngological Association, the American Laryngological, Rhinological and Otological Society, American Otological Society and a Fellow of the American Academy of Surgeons. He is a graduate of University of Wisconsin Medical School, 1915. Dr. Furstenberg will speak on "Diseases of the Salivary Glands" before the Section on Eye, Ear, Nose and Throat at 11:15 a. m., Tuesday, in the Hall of Mirrors, Deshler-Wallick Hotel.

Joseph W. Gale, M. D., Madison, Wis., is professor of surgery at the University of Wisconsin Medical School and associate surgeon in charge of thoracic surgery at the State of Wisconsin General Hospital. He is a member of the American Association for Thoracic Surgery. He received his degree from Washington University School of Medicine, 1924. Dr. Gale will speak on "The Crippled Lung" at 4:10 p. m., Tuesday, before the General Session in the Main Ballroom of the Neil House.

Frank Glenn, M. D., New York City, is professor of surgery at Cornell University Medical College, and surgeon-in-chief at New York Hospital. A graduate of Washington University School of Medicine, 1927, he is a member of the American Surgical Association, the Society of University Surgeons, the Society of Clinical Surgery and other professional societies. Dr. Glenn will discuss "Current Trends in the Surgical Treatment of Hernia," before the Section on Surgery at 10:30 a. m., Tuesday, in the Main Ballroom at the Neil House.

Franklin D. Johnston, M. D., Ann Arbor, Mich., is associate professor of internal medicine at the University of Michigan Medical School. He is a graduate of the same school, class of 1929, and is a member of the Central Society for Clinical Research and the American Society for Clinical



C. S. CAMERON, M. D.



A. C. FURSTENBERG, M. D.



F. D. JOHNSTON, M. D.



W. T. TOMPKINS, M. D.

Investigation. Dr. Johnston will speak on the subject, "Examination of the Heart From the Standpoint of the General Practitioner," at 10:20 a. m., Wednesday, before the Section on General Practice in the Main Ballroom of the Neil House; also he will speak before the Section on Medicine in the same auditorium at 9:30 a. m., Thursday, on the subject, "Unipolar Lead Electrocardiography."

John R. Neefe, M. D., Philadelphia, Pa., is associate in medicine, University of Pennsylvania Medical School, and is senior ward physician, Department of Medicine, Hospital of the University of Pennsylvania. He is a graduate of the same medical school, 1940; is a member of the American Society for Clinical Investigation, the American Gastroenterological Association, the Subcommittee on Liver Diseases, National Research Council, and the Commission on Liver Disease of the Army Epidemiological Board. Dr. Neefe will speak before the Section on Medicine at 9:00 a. m., Thursday, in the Main Ballroom of the Neil House on the subject, "Residual Hepatic Disturbances in Viral Hepatitis"; and at 4:14 p. m., on the same day, he will discuss "Recent Developments in Viral Hepatitis and Other Liver Diseases," before a General Session in the same hall.

Henry S. Ruth, M. D., Philadelphia, Pa.; is professor and head of the Department of Anesthesiology of Hahnemann Medical College and Hospital of Philadelphia, Inc. He is a graduate of the same college, class of 1923, is a member of the American Society of Anesthesiologists of which he is a past-president, fellow of the American College of Anesthesiologists, and of the International College of Surgeons. Dr. Ruth will speak on two occasions. Before the General Session in the Main Ballroom, Neil House, he will speak at 4:45 p. m., Tuesday, on the subject, "Anesthesiology as an Aid to Diagnosis and Treatment." He will speak before the Section on Anesthesiology in Parlors A-C, Deshler-Wallick Hotel at 10:15 a. m., Tuesday, on the subject, "Anesthesia in Thoracic Surgery."

Philip M. Stimson, M. D., New York City, is associate professor of clinical pediatrics, Cornell University Medical College, and director of poliomyelitis service, Knickerbocker Hospital, associate attending pediatrician, New York Hospital, medical director, Floating Hospital St. John's Guild and visiting physician at Willard Parker Hospital. Dr. Stimson will speak on the subject, "The Diagnosis and Treatment of Early Poliomyelitis," before the General Session in the Main Ballroom, Neil House, at 4:10 p. m., Thursday.

Winslow T. Tompkins, M. D., Philadelphia, Pa., is associate in obstetrics, University of Pennsyl-



J. W. GALE, M. D.



FRANK GLENN, M. D.



H. S. RUTH, M. D.



P. M. STIMSON, M. D.

vania Graduate School of Medicine, and assistant obstetrician and gynecologist to Pennsylvania Hospital. He is a graduate of the same medical college, 1930; is a member of the Philadelphia Obstetrical Society. Dr. Tompkins will speak on the subject, "The Clinical Significance of Nutritional Deficiencies in Pregnancy," at 10:00 a. m., Wednesday, before the Section on Obstetrics and Gynecology in the Hall of Mirrors, Deshler-Wallick Hotel.

Louis Weinstein, M. D., Boston, Mass., is assistant professor of medicine at Boston University Medical School and instructor in infectious diseases at Harvard Medical School, and chief of infectious disease service, Massachusetts Memorial Hospital. He is a graduate of Boston University Medical School, 1943, is a member of the American Society for Clinical Investigation and the Society for Experimental Biology and Medicine. Dr. Weinstein will speak on "The Newer Antibiotics," before the Section on Pediatrics in Parlors A-C, Deshler-Wallick Hotel at 11:00 a. m., Thursday.

National Health Meeting Now Termed "Impractical"

Any proposal for the American Medical Association to call a National Health Conference "would be impractical," according to Dr. Elmer L. Henderson, Louisville, Ky., chairman of the Board of Trustees, until the Federal Security Administration makes a full report on the 16 sections which comprised Federal Security Administrator Oscar Ewing's National Health Assembly, held in Washington in May, 1948.

In a statement published in the March 19 issue of *The Journal of the American Medical Association*, Dr. Henderson said that "the reports of these sections have not yet become available except for the inclusion of the condensed report of the section on medical care.

"When the full reports become available, the valuable material developed at the National Health Assembly may well serve as a basis of discussion and implementation of any program for the extension of medical care. When the National Health Assembly adjourned, most of those in attendance believed that the executive committee would carry on the studies and recommendations of that conference, but thus far only one meeting has been held," Dr. Henderson stated. "Otherwise, as far as can be determined, nothing has been done.

"The Board of Trustees wishes it clearly understood that it is prepared at the proper time not only to continue conferences already instituted but to do whatever else is necessary to assure a better distribution of the high quality of medical care now existing in the United States," he concluded.

National Health Institute To Be Held in Cincinnati

A National Institute on Community Health will be held at the Netherlands Plaza Hotel, Cincinnati, on April 7, beginning at 9:30 a. m., under sponsorship of the Chamber of Commerce of the United States with the following co-sponsors: Ohio Chamber of Commerce, Cincinnati Chamber of Commerce, Pennsylvania and Indiana Chambers of Commerce.

"Believing that more effective community health work is highly desirable, this Institute is held to stimulate the interest of businessmen and business organizations in their community health problems and to foster intelligent action," according to Ralph Bradford, executive vice-president of the national organization.

The program will include a report on health progress in the nation, and reports of contribution by the medical profession, hospitals, science and research, and governmental public health service. The importance of industrial health will be among subjects discussed.

Summations of work done in Atlanta, Ga., and Farrell, Pa., will be included on the afternoon program.

Among speakers on the program are: Earl O. Shreve, president of the Chamber of Commerce of the U. S.; A. D. Marshall, assistant secretary, General Electric Co.; Dr. G. M. Wheatley, third vice-president, Metropolitan Life Insurance Co.; Albert V. Whitehall, executive director, Washington Bureau, American Hospital Association; Dr. R. J. Miller, Connecticut Medical Society; O. C. Hubert, realtor, Atlanta, Ga.; Herbert Garster, businessman of Farrell, Pa., and Robert A. Hornby, vice-president, Pacific Lighting Corporation, San Francisco, Calif.

A. M. A. To Begin 1949 Hospital Survey

Plans to conduct a 1949 survey of all hospitals approved for intern or resident training were outlined recently at a one-day conference of the regional representatives of the Council on Medical Education and Hospitals of the American Medical Association.

The council's representatives will visit a number of hospitals during the coming months, acting in an advisory capacity, both to the hospitals and the council. Regional appointments have been made for all areas presently included in the project. Secretary of the council is Dr. Donald Anderson.

The first school of medical illustration in the southeastern United States has been opened at the University of Georgia School of Medicine, Augusta. The courses are designed to equip illustrators for all types of scientific illustration.

ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1948, BY KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand at January 1, 1948:

Cash in Huntington National Bank	$ 8,147.36	
Cash in Ohio National Bank (1948 dues)	53,565.00	
U. S. Treasury and Savings Bonds	65,000.00	
Total cash and bonds on hand January 1, 1948		$126,712.36

RECEIPTS

Interest on U. S. Treasury and Savings Bonds	$ 1,937.50	
1948 Membership dues collected in 1948	55,173.00	
1949 Membership dues collected in 1949	60,195.00	
1948 Annual Meeting Exhibit space collected in 1948	5,045.00	
1949 Annual Meeting Exhibit space collected in 1948	3,631.00	
1948 Annual Meeting Banquet Ticket Sale	3,935.00	
Membership Directories sold	432.00	
Refund Annual Meeting Expense	409.70	
Refund of Auditing expense by The Journal	50.00	
Refund of Social Security Tax by The Journal	2.60	
Refund on paper	3.75	
Public Relations literature sold	8.13	
Total receipts		$130,822.68
U. B. Bonds purchased in 1948		5,000.00
Total To Be Accounted For		$262,535.04

DISBURSEMENTS

Ohio State Medical Journal	15,000.00	
Executive Secretary, salary	9,000.00	
Executive Secretary, expense	1,186.05	
President, expense	791.97	
Stenographic and clerical personnel, salaries	10,909.28	
Council, expense	1,908.23	
A. M. A. Delegates, expense	2,463.17	
Conference of County Society Presidents and Secretaries	615.17	
Department of Public Relations ($21,383.94):		
Director, salary	7,500.00	
Director, expense	1,307.51	
Assistant Director, salary	4,300.00	
Assistant Director, expense	648.87	
Exhibits and newspaper publicity	1,968.24	
Literature	4,056.96	
Postage and supplies	602.36	
Contribution to Ohio Rural Health Council	1,000.00	
Committee on Education	120.41	
Committee on Public Relations and Economics	75.58	
Committee on Scientific Work	687.55	
Committee on Auditing and Appropriations	250.00	
Committee on Cancer	23.59	
Committee on Industrial Health	82.95	
Committee on Medical Service Plans	17.60	
Committee on National Emergency Medical Service	248.50	
Committee on Postgraduate Programs	1,870.01	
Committee on Rural Health	355.86	
Miscellaneous Committees	251.06	
Annual Meeting	15,919.11	
Retirement Fund	2,282.64	
Postage, telegraph, and telephone	1,932.42	
Professional Relations Activity	4,273.22	
Stationery and Supplies	1,945.89	
Rent	5,574.00	
Employees' position bond	30.00	
Industrial insurance	17.29	
Insurance, general	53.94	
Social security taxes	465.26	
Refund of Banquet Tickets	65.00	
Refund of overpaid dues	40.00	
Remodeling offices	667.96	
Appropriation to Woman's Auxiliary Bulletin	250.00	
Fifty-Year membership emblems	1,647.63	
Purchase of U. S. Savings Bonds, Series G	5,000.00	
Total disbursements		$107,405.28

Cash on Deposit and Bonds on Hand, December 31, 1948:

Huntington National Bank	$ 24,934.76	
Ohio National Bank	60,195.00	
U. S. Savings Bonds, Series G	50,000.00	
U. S. Treasury Bonds	20,000.00	
Total cash and bonds on hand, December 31, 1948		$155,129.76
Total Accounted For		$262,535.04

THE OHIO STATE MEDICAL JOURNAL

Balance Sheet at December 31, 1948

ASSETS

Current Assets:		
Cash in Ohio National Bank		$ 3,337.49
Petty cash		10.00
Total cash		$ 3,347.49
Postage deposit		65.00
Accounts Receivable:		
Advertisers		1,802.63
Ohio State Medical Association		11.25
Total current assets		$ 5,226.37
Property Assets:		
Furniture and Fixtures (depreciated values)		8,553.76
Total Assets		$ 13,780.13

SURPLUS

Surplus, December 31, 1947	12,440.10
Net income for year ended, December 31, 1948	1,125.03
Prior years' postage deposit	65.00
Prior years' prepaid subscriptions	150.00
Total Surplus, December 31, 1948	$ 13,780.13

STATEMENT OF PROFIT AND LOSS

Income:		
Advertising, Gross		$ 31,578.33
Less:		
Commission on advertising	$ 1,885.07	
Discount on advertising	968.75	2,853.82
Advertising income, net		$ 28,724.51
Ohio State Medical Association appropriation		15,000.00
Subscriptions and sales		565.49
Miscellaneous receipts		11.00
Total revenue, net		$ 44,301.00
Expenses:		
Journal printing	$ 29,580.28	
Printing, miscellaneous	296.92	
Salaries	9,080.00	
Traveling expense	205.73	
Journal postage	804.71	
Illustrations and engravings	299.15	
Journal envelopes	1,065.12	
Depreciation	888.35	
Clipping service	190.00	
Dues and subscriptions	43.28	
Office supplies and expense	617.90	
Audit, inventory, miscellaneous expense	104.53	43,175.97
Net Income for the Year		$ 1,125.03

On the Firing Line . . .

Shots At Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"The Federal government, which bears down now on the individual taxpayer with greater pressure than all state and local tax pressures combined, has an inescapable moral obligation first to make a decent and genuine effort to reduce its expenditures. It has a moral obligation to trim its requests in all categories, certainly including those for foreign aid programs and especially those envisaging important new socialistic advances at home."—*The Columbus Dispatch.*

* * *

"President Truman's proposal to increase payroll deductions is purely an income tax on the wage earner. Eventually the people will realize how far along the road they are going toward nationalization and socialization and put a halt to it."—*Representative Reed of New York.*

* * *

"The program of the A. M. A. is comprehensive and thorough. It calls for a minimum of bureaucratic controls and a minimum of governmental domination. The administration's plan for compulsory health insurance on the other hand would produce governmental interference in almost every move made in the doctor-patient relationship. Under government compulsory insurance they would not, as has been claimed, be assured of getting the services of the doctor they wanted; they might not even be able to retain the services of the physicians they now consult."—*The Ohio State Journal.*

* * *

"The American Medical Association used the Truman administration's own figures in an effort to demonstrate that the government's proposal for socialized medicine would cost the nation more than 18 billion dollars a year, 'just a starter.'

"Dr. George Fairless Lull, general manager of the A. M. A., said that instead of the 3 or 4 per cent pay roll tax recommended by Federal Security Administrator Oscar R. Ewing, the Ewing plan for compulsory health insurance would probably take 10 per cent from every pay roll."—*John H. Thompson in the Chicago Tribune.*

"Although the British people may think they are getting all this medical and dental service for nothing, somebody has to pay for it. The Ministry of Health originally had estimated the cost for the first nine months in England and Wales at $558,000,000. But the ministry has just obtained a supplementary appropriation of $211,200,000 . . . Where does the British government get the money to pay for these services? At least part is paid for by British taxpayers in the form of payroll deductions. But there is question as to whether the British economy could support socialized medicine without the benefits it receives in the form of Marshall Plan aid."—*Cleveland Plain-Dealer.*

* * *

"The costs of medical care and social security are to be raised to new heights, on the theory that American medical care, the best in the world, can be improved if it is made as much as possible like the medical care in France and England, where it is terrible.—*The Saturday Evening Post.*

* * *

"It is all very well for Great Britain and its Labor Government to install its cradle to grave security programs. It has the United States and its wealth to depend upon for loans and gifts and aid of all kinds. The United States can depend on no other nation for help." . . . —*The Columbus Dispatch.*

* * *

"There are aggressive plans to push through Congress a compulsory health insurance act. This is a part of the present administration's program. Insurance writers should demonstrate that private insurance companies can do better than the government in providing sickness and accident insurance protection and service for the wage earners of America."—*Frank L. Barnes, vice-president and director of agencies, Ohio State Life Insurance Company.*

* * *

"Pay roll taxes could conceivably bankrupt America and do exactly what the Communists want done to undermine American stability.

"This in substance is the view expressed by Sen. A. Willis Robertson of Virginia, Democrat,

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in a speech just delivered . . . The Virginia Senator then analyzes the recommendations of the President for larger taxes on pay rolls. . . . 'At one hearing of the Ways and Means Committee on the subject, some economists placed a total of such pay roll taxes at 20 per cent. If the tax should reach that rate and with Mr. Ewing's proposal that the tax apply to incomes up to $4,800, the half paid by employes would go as high as $40 a month in addition to all other taxes!' "—*As reported by David Lawrence.*

* * *

"If the American people do not want (1) to receive medical care on a basis of a two or three-minute consultation with an overworked doctor or (2) to stand for a compulsory pay-roll tax for this type of service, anyway, and then pay the usual fee for adequate professional attention, they should let Congress know it when the administration's bill for socialized medicine comes up for consideration."—*The Columbus Dispatch.*

* * *

How will such a vast program, affecting every man, woman and child, be carried on if a depression strikes?

* * *

"The public had been led by our Socialist tub-thumpers to suppose that with the coming of the N. H. S., a medical Utopia would dawn for them. In point of fact the ordinary working-class patient is less well off than he was before the Scheme started. You will appreciate that the N. H. S. has brought no more doctors, no more nurses, no more hospital beds, and indeed, no more facilities of any kind into service with the result that there are now infinitely more people competing for the same amount of facilities . . ."—*H. A. H. Harris, Chelmsford, England.*

* * *

". . . Truly the Hippocratic ideal which has determined the complete confidence of the patient in his doctor in regard to professional secrecy has been badly shattered for patients who are treated under the Act; and the doctors are, in the future, to be subjected to the degrading position of breaking the Hippocratic oath when having to submit to the Minister's appointed 'snoopers.' "—*Sir Ernest Graham-Little, Member of Parliament, regarding British Compulsory Health Insurance.*

* * *

"In my own opinion there is a good deal too much preoccupation with illness and too great a tendency to assume that health can be purchased at a drug store or in a doctor's office. Too often an increase in the number of doctors simply means an increase in disease, since there are very few human beings who do not suffer a number of ailments, real or imaginary."—*Jay Franklin.*

"Ask any G. I. how medical care on the assembly line basis works out. The hypochondriacs have a field day and those who are really sick never get to the head of the line."—*Bob Robinson in Appleton City Journal.*

* * *

"Mr. Ewing in his report charged that only 20 per cent of the American people can afford all the medical care they need. If the other 80 per cent cannot afford to pay voluntary health insurance premiums, how can they afford additional social security taxes to support more government workers."—*John L. Bach in "Pickpocket Medicine."*

* * *

"The government's latest proposal for socialized medicine would necessitate a new payroll tax of approximately nine per cent, which would amount to $450 on a $5,000 salary, and, in addition, the adding to the public payroll of at least 300,000 administrative workers."—*John L. Bach, in "Pickpocket Medicine."*

* * *

"The Law, The Church, and Medicine, should be beyond the reach of contamination of political control."—*D. R. Goodfellow, Manchester, England.*

* * *

"The Truman administration's vast program for national social security and medical care will, if approved by congress, cost a minimum of 12 billion dollars a year by 1955 and even more in the years to follow, congressional economists estimate.

"It is further estimated that to finance this program, the combined pay roll taxes levied on employers and workers will be increased from the present 3½ per cent to 11 per cent six years from now."—*Robert Young in the Chicago Tribune.*

* * *

Those war veterans who are entitled to free medical and hospital care under existing law will have to pay the compulsory payroll tax to provide medical care to others.t

* * *

"The first instinct of bureaucracy is self-preservation. The second is expansion. Like any living organism, an administrative agency, once launched, seeks constantly to justfy its existence, to perpetuate itself and to expand.

"The real nucleus, the driving spirit, in the campaign to socialize American medicine, lies within this sprawlng branch of Federal government."—*Forest A. Harness, former Congressman from Indiana and chairman of the Subcommittee on Publicity and Propaganda.*

Hospital Building Program . . .

Five Ohio Projects Now Under Construction and Fifteen More Approved During Two-Year Period for Participation in Funds Under Hill-Burton Law

TWENTY-ONE hospital construction projects in Ohio, representing an estimated total cost of more than $18,000,000, have been approved for the first two years of participation under the Federal Hill-Burton Law, officials of the Ohio Department of Health reported.

During the first fiscal year in which Ohio participated in the program, July 1, 1947-June 30, 1948, ten projects were approved. The additional 11 projects were approved for the fiscal year ending June 30, 1949. Provisions of Public Law 725 (Hill-Burton Law) require the local sponsoring agency to furnish the ground and two-thirds of the building and equipment cost, while the Federal government furnishes one-third of the cost. The local group also must assume responsibility for support and maintenance of the project.

Of the 21 approved projects, six are now under construction and construction on at least two others is scheduled to begin during the spring.

FIRST YEAR PROJECTS

Projects approved under the first year's appropriation, with a progress report, estimated total cost and other data, are the following:

Memorial Hospital of Fayette County, Washington C. H.; general hospital and health center; 34 beds, 15 bassinets; county sponsored; $630,000; construction began recently.

Greene County Hospital, Xenia; general with outpatient department and public health center; 75 beds, 27 bassinets; county sponsored; $1,214,000; construction scheduled to begin in April.

Ashtabula General Hospital, Ashtabula; general hospital with outpatient department (replacement of existing hospital plant); 109 beds, 25 bassinets; N. P. A. (non-profit association); $1,692,600; construction expected to begin by early summer.

Mount Saint Mary Hospital, Nelsonville; general hospital with outpatient department and public health center; 74 beds; 15 bassinets; non-profit association (church); $1,256,965.88; construction now underway and expected to be substantially completed during 1949.

Defiance Hospital, Defiance; general with outpatient department and public health center; 49 beds, 22 bassinets; city sponsored; $855,000; still in planning stage.

Clinton Memorial Hospital, Wilmington; general hospital; 65 beds, 28 bassinets; county; $879,200; plans nearly completed.

Richland County Tuberculosis Sanitorium, Mansfield; tuberculosis sanitorium with outpatient department; 84 beds; county; $788,025.58; construction well advanced and contractors estimate building will be completed by December.

Mary Rutan Hospital, Bellefontaine; general, 34-bed addition to existing hospital; 75 beds, 27 bassinets; city; $438,221.82; construction began in February.

Brown Memorial Hospital, Conneaut; general, 35-bed addition to existing hospital; 60 beds, 16 bassinets; N. P. A.; $522,000; plans well advanced.

Memorial Hospital of Geneva, Geneva; general; 24 beds, 12 bassinets; N. P. A.; $348,000; plans well advanced.

SECOND YEAR PROJECTS

Projects approved under the second year's appropriation (ending June 30, 1949), are the following, all of which are in the planning stage except the two designated as under construction.

Wood County Hospital, Bowling Green; general with provisions for further additions for outpatient department and health center; 54 beds, 21 bassinets; N. P. A.; $750,000.

Union Hospital, Dover; general with public health center combined, replacement; 97 beds, 38 bassinets; N. P. A.; $939,609.56.

St. Joseph Hospital, Lorain; general, addition of 68 beds to existing hospital; 194 beds, 50 bassinets; N. P. A.; $725,527.24.

Wooster Community Hospital, Wooster; general and public health center; 70 beds, 21 bassinets; publicly owned; $1,369,986.66; construction well under way.

Guernsey Memorial Hospital, Cambridge; general, with provision for public health center on alternate bid; 66 beds, 22 bassinets; N. P. A.; $1,050,000.

Wyandot Memorial Hospital, Upper Sandusky; general; 25 beds, 10 bassinets; N. P. A.; $361,100.

Union County Hospital, Marysville, general and community health center; 25 beds, 12 bassinets; publicly owned; $540,000.

Hardin Memorial Hospital, Kenton; general; 44 beds, 8 bassinets; N. P. A.; $540,000; construction started before project was brought under Hill-Burton Law; new plans now being studied.

Elyria Memorial Hospital, Elyria; general, addition of 80 beds to existing hospital; 177 beds, 33 bassinets; N. P. A.; $1,411,000.

Chillicothe Hospital, Chillicothe; general, ad-

dition of 51 beds to existing hospital, possible health center; 106 beds, 26 bassinets; N. P. A.; $975,000.

BALANCE SOUGHT

Projects are now being considered for participation in the third year's appropriation of the five-year plan, Anthony J. Borowski, Dr. P. H., administrator of the Ohio program, reported. Special consideration is being given to needed hospitals for chronic diseases and other related fields for the third year participation. The program calls for an appropriate balance in the construction of the various categories of facilities for general hospitals, tuberculosis, mental, chronic disease hospitals and health centers.

Priority ratings of areas determined by a survey of hospital needs are still in effect. Of the 13 projects in the A priority group (those with no acceptable hospital facilities), four have been approved and at least five others are expected to become projects during the life of the program.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since February 1, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

BUTLER COUNTY
Judd W. Uhl, Hamilton

CLARK COUNTY
Wesley E. Knaup, Springfield

CRAWFORD COUNTY
John A. Beall, Galion

CUYAHOGA COUNTY
William K. Hokr, Cleveland
Frank J. Imburgia, Cleveland
Saul Kottler, Lakewood
Stanley F. Radzyminski, Cleveland
Viola V. Startzman, Cleveland

FAIRFIELD COUNTY
James C. Beesley, Lancaster

FRANKLIN COUNTY
Margaret W. Bridwell, Columbus
Constance J. Connors, Columbus
Virgil L. Cross, Columbus
C. Alton Day, Columbus
Samuel Finck, Columbus
Leo E. Froomess, Columbus
Willis H. Hodges, Jr., Columbus
Herbert L. Pariser, Columbus
Merle L. Phillips, Columbus
Gerhard T. Shearer, Columbus
Carl E. Tetirick, Columbus
Watson H. Walker, Columbus

GREENE COUNTY
Harry M. Berley, Yellow Springs
Norman G. Linton, Jamestown
H. C. Stoneburner, Spring Valley

HAMILTON COUNTY
Luther J. Lemon, Cincinnati

JACKSON COUNTY
David S. Mack, Jackson

LAWRENCE COUNTY
George N. Spears, Ironton

LUCAS COUNTY
Donald K. Harrison, Maumee

MONTGOMERY COUNTY
Darrell C. Caudill, Dayton

MORROW COUNTY
Stanley L. Brody, Cardington
William S. Deffinger, Marengo

OTTAWA COUNTY
Luebert L. Docter, Genoa

SCIOTO COUNTY
Wayne H. Pitcher, Portsmouth

STARK COUNTY
James M. Muckley, Canton
Thomas B. Shipley, Canton
Merle K. Singer, Massillon
Clarence V. Smith, Canton
Jack L. Yahraus, Canton

SUMMIT COUNTY
William H. Dumeyer, Akron
Lewis E. Rector, Akron
James H. Strauch, Akron
Carroll F. Tatum, Akron

Survey Started To Find Solution For Nursing Shortage

A nation-wide survey of schools of nursing is being undertaken by six national nursing organizations in order to provide a basis for gearing education facilities to meet the country's urgent nursing needs.

The survey will cover all of the 1,215 state-accredited schools of nursing and will be completed by June 30. It will be conducted by a joint committee of representatives of the American Association of Industrial Nurses, the American Nurses' Association, the Association of Collegiate Schools of Nursing, the National Association of Colored Graduate Nurses, the National League of Nursing Education, and the National Organization for Public Health Nursing.

Chairman of the committee is Mary C. Connor, Research Associate of the Division of Nursing Education, Teachers College, Columbia University, New York City.

The national survey will assess the nation's current nursing assets in terms of future needs; show which needs must be met first; assist in selective recruitment efforts; make it possible to classify schools of nursing; and demonstrate what additional funds are necessary for nursing education.

Miss Connor pointed out that the present shortage of nurses is so acute that some hospitals have been compelled to close wards. The number of students enrolling in schools of nursing is increasing again. In 1946 there were only 30,900 new students. About 43,000 were admitted this year. Miss Connor said the need for nurses continues to mount and stated that recent estimates indicate that at least 60,000 new students should be admitted in 1950 to meet minimum needs.

Opinion of Attorney General

Following is the syllabus of a recent opinion rendered by Attorney General Hugh S. Jenkins:

Opinion No. 4173: The duty of supervising all hospitals and other institutions for the care and treatment of tuberculosis, both privately and publicly owned is, under the terms of Section 3139, General Code, enjoined upon the State Department of Health.

Internships-Residency

Rotating internships and a general residency are available at the Wheeling Hospital, W. Va., July 1, to graduates of approved medical schools. The 250-bed general hospital is approved by the A. M. A. and the A. C. S. Women are accepted. Stipends are $100 and $200 per month plus maintenance. Further information may be obtained by writing to the superintendent.

Committee Activities . . .

The Council Receives Reports on Education, Cancer and Industrial Health; Postgraduate Seminars Mapped; Plans Laid for Speaking Teams

THE Committee on Education of the Ohio State Medical Association, in a report approved by The Council, voted to limit the Association's fall postgraduate seminars this year to two meetings. The first of these meetings will be held in Athens and the second will be held about a month later in Columbus, with the same program to be given at each seminar. The time in each case will be from 1:30 to 5:30 p.m.

The committee discussed the postgraduate seminars which were held in Chillicothe, Lima and Mansfield last fall and reviewed the comments, criticisms and suggestions which had been made concerning the sessions. It agreed:

1. That the visual method of presentation used at Mansfield was very effective, but that the talks should be shorter when slides are used, preferably 30 minutes.
2. An effort should be made to eliminate visual distractions on the speakers' platform, such as the flags, etc., which were at the back of the stage at the Chillicothe meeting.
3. The evening meeting should be eliminated.
4. The talks should be preceded by a brief, explanatory introduction of the course by the moderator or presiding officer.
5. A five-minute intermission after each talk is preferable to a 15-minute recess.
6. The results of the experiment last fall of having each meeting devoted to one subject were sufficiently good to warrant continuation of that type of program.

Complete details for the fall seminars will be worked out by the committee.

Among other matters discussed at the meeting was the committee's former suggestion concerning a survey of physicians in practice for comments and criticisms on the conduct of medical education. The matter has been referred to the Committee to Survey Medical Education of the A. M. A. where it is now being considered.

The questions of selection of medical students and of the possibilities for increasing enrollment in medical schools, referred to the committee by The Council, for consideration, were considered. The committee felt that it should defer further consideration, awaiting the report of the National Survey of Medical Education now being conducted by the A. M. A. and the Association of American Medical Colleges.

The Committee on Education met on January 23, with the following members in attendance: Dr. Carl A. Wilzbach, Cincinnati, chairman; Dr. J. Edwin Purdy, Canton; Dr. J. L. Webb, Nelsonville; Dr. Thomas E. Rardin, Columbus; Dr. Edwin P Jordan, Cleveland; and members of the Columbus Office staff.

COMMITTEE ON CANCER

Foundations for an educational program in the control of cancer, directed primarily toward reaching physicians who are not specializing in cancer, were laid at a meeting of the Committee on Cancer of the Ohio State Medical Association, and reported to The Council at its meeting of February 27.

There was general discussion of how best to carry on this educational program throughout Ohio. Members expressed themselves as believing that there is a need for reaching physicians who are not specializing in cancer and especially to reach those who for one reason or another do not attend medical meetings regularly. It seemed to be the unanimous opinion that programs should be presented to smaller groups rather than at so-called state-wide institutions.

Dr. Walter B. Lacock, head of the Division of Cancer, Ohio Department of Health, upon request of the committee, consented to investigate the educational program being carried on in Tennessee, and to report his findings at the next meeting of the committee.

On authorization of the committee, the chairman appointed a subcommittee to prepare a detailed draft of programs which can be arranged for presentation at county society meetings or at joint county society meetings. The subcommittee was specifically instructed to enumerate subjects to be presented, types of speakers to be used, time schedules, mechanics for carrying on the program, and how the teams of speakers would be selected. The chairman appointed the following: Dr. John H. Lazzari, Cleveland, chairman; Dr. L. A. Pomeroy, Cleveland; and Dr. Robert T. Allison, Jr., Akron.

The committee voted to invite the Ohio State Dental Society to select a representative to meet with the committee in an ex-officio capacity.

Members discussed a request from the Ohio Department of Health, submitted to it by The Council, as to whether cancer should be made a reportable disease in Ohio. It was the consensus of opinion that no action be taken on this question at the time. Dr. John D. Porterfield, director of the Ohio Department of Health, was requested to investigate further the possibilities of setting up a reporting and statistical agency

on cancer morbidity and mortality, perhaps like the Connecticut plan, without making cancer a reportable disease. Dr. Porterfield consented to do this and report to the committee at its next meeting.

The Executive Secretary was authorized to distribute to the chairman of the cancer committee of each county medical society a copy of the handbook of the American Cancer Society, "Program Service Handbook."

The committee met on January 23. Members presented were: Dr. C. E. Hufford, Toledo, chairman; Dr. Lazzari, Dr. Carl A. Wilzbach, Cincinnati; Dr. Pomeroy, Dr. Robert M. Zollinger, Columbus, and Dr. W. D. Nusbaum, Lancaster. Others present were Dr. Carl A. Lincke, Carrollton, President-Elect of the Association, Dr. Porterfield, Dr. Lacock, and members of the Columbus Office Staff.

INDUSTRIAL HEALTH

A meeting of the Committee on Industrial Health and Workmen's Compensation was held in the Columbus Office on February 5, and a report of this meeting was approved by The Council on February 27. Members of the committee present were: Dr. H. P. Worstell, Columbus, chairman; Dr. F. G. Barr, Dayton; Dr. George F. Sykes, Cleveland; Dr. Robert A. Kehoe, Cincinnati; Dr. Louis N. Jentgen, Columbus; Dr. James N. Wychgel, Cleveland; Dr. Warren A. Baird, Toledo; Dr. A. L. Bershon, Toledo; and members of the Columbus Office Staff.

Chairman Worstell reported on the recent A. M. A. Congress on Industrial Health in Chicago, stating that it was one of the best meetings of that kind he had attended and that there were indications that the medical profession and labor groups were getting closer together on activities of this kind.

A request from the Ohio State Safety Conference, that the Ohio State Medical Association serve in an advisory capacity on the matter of providing a program for the section on industrial health for the conference which will be held September 20-22, 1949, in Cleveland, was considered. This matter had been referred to the committee by The Council with authorization to cooperate. On motion duly made, seconded and carried, the chairman was authorized to appoint a subcommittee to work out a program and suggestions on this matter.

A request from the Veterans Employment Service of the United States Employment Service, asking for assistance on an educational program among physicians on the matter of rehabilitation of the disabled veteran, was discussed. On motion duly made, seconded and carried, the committee decided that this matter should be discussed with the officials of the foregoing agency and with the State Bureau of Rehabilitation in an effort to try to work out copy for a series of brochures relating to rehabilitation, employment of handicapped persons, etc., which would be distributed to Ohio physicians.

Chairman Worstell reported on negotiations with the Industrial Commission regarding certain increases in the medical and surgical fee schedule. He stated that the recommendations of the Association had been presented formally to the Commission and were now under consideration by the Commission.

Lithium Chloride Products Declared Dangerous

In a recent official communication to all local health commissioners in the State, Dr. John D. Porterfield, director of the Ohio Department of Health, stated that he had been advised by the Federal Food and Drug Administration to assist in stopping all sales and use of lithium chloride products. Specifically placed on the recall list were the proprietary products known as "Westsal," "Foodsal," and "Saltisalt."

According to an article in the March 12 issue of *The Journal of the American Medical Association*, three deaths and nine additional known cases of poisoning among persons using salt substitutes containing lithium chloride have been reported from Cleveland, New York and Beverly Hills. *The Journal of the A. M. A.*, in addition to the three previously mentioned, includes the proprietary product "Milosal."

No salt substitute containing lithium chloride has been approved by the A. M. A., either by the Council on Pharmacy and Chemistry or by the Council on Foods and Nutrition, an A. M. A. release states. The release further informs that although potassium salts and other substances besides lithium have been employed for many years as substitutes for ordinary table salt without producing detrimental effects, their use has proved unsatisfactory from the standpoint of taste and some authorities believe they require further study before they should be recommended as entirely harmless.

Gastroenterological Award

The National Gastroenterological Association again announced its Annual Cash Prize Award Contest for 1949. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy. The award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in October of 1949. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

Rural Medical Scholarships . . .

Association Will Aid Medical Student From Rural Area Annually As Part of Program To Stimulate Interest in Country Practice

AT a meeting held February 20 in the State Headquarters Office, the Ohio State Medical Association Committee on Rural Health developed the final outline of a rural medical scholarship plan which was approved by The Council of the Association a week later.

To be known as "The Ohio State Medical Association Rural Medical Scholarship," the purpose of the plan is "to stimulate interest on the part of rural young men and women in the study of medicine, with the belief that because of their interest in rural life, they will later establish medical practice in rural communities."

TO BE STARTED IN 1949

The scholarship, which will be initiated this year, will be administered by the Committee on Rural Health, with the aid of an advisory committee composed of representatives from the various rural and educational organizations of the state, who will generally promote the scholarships among rural people.

The amount of the grant will be $500 per recipient per school year, awarded for a four-year period, subject to acceptable work on the part of the student. No obligations other than that will be attached to the scholarship. It is restricted to Ohio residents, but may be used at any approved medical school in the country.

SERIES OF LECTURES

A subcommittee was named to draft a series of four lectures for a proposed course in rural general practice of medicine for the consideration by deans of Ohio's medical schools. It will be suggested that this series be included in any curriculum which comprises a course in the general practice of medicine. This group, which includes Drs. J. Martin Byers, Greenfield, Jonathan Forman, Columbus, and Edmond K. Yantes, Wilmington, was also designated to select suggested teaching personnel for the course.

The Committee on Rural Health also set up the outline of a handbook to be used as a guide for county medical society rural health committees. This booklet, which will be published later in the year, will contain detailed suggestions for dealing with rural health problems; short articles on immunization, farm sanitation, and rural nutrition; and a bibliography of various rural health subjects.

Attending the meeting were: Dr. A. A. Brindley, President of the Ohio State Medical Association; Dr. Carl A. Lincke, President-Elect; Dr. Carll S. Mundy, chairman of the Committee; Drs. Forman, W. B. Recker, W. B. Taylor, H. R. Mayberry, Yantes, and Byers, members of the Committee; Secretaries C. S. Nelson, H. F. Page, and R. G. Moore; and Sewall O. Milliken, extension specialist in Rural Health, Ohio State University.

Crippled Children's Society Launches Campaign

A goal of $385,000 has been set for Ohio for the 16th annual Easter Seal Sale, James A. Hewitt, president of The Ohio Society for Crippled Children, announced. The nation-wide drive opened March 17 and closes Easter Sunday, April 17. The society's headquarters are at 5 W. Broad St., Columbus 15.

Sheets of Easter Seals have been mailed to nearly two million families in the state with an appeal for a dollar or more to support services for the physically handicapped. Ninety-three affiliated county societies for crippled children and cooperating service groups join with the state society in conducting the campaign.



Funds contributed through purchase of the seals, Mr. Hewitt stated, will be used for medical care; corrective braces, shoes and other artificial aids; equipment for therapy; recreation and camping; training of urgently needed professional personnel, and many other services.

More than 90 per cent of the money collected is scheduled to remain in the state; the balance or eight and three tenths per cent will represent Ohio's share in the support of educational and other activities of The National Society for Crippled Children and Adults.

Physician-Artists

Those who plan to exhibit at the Atlantic City Exhibition, American Medical Association, June 6-10, should write for entry blanks, rules, shipping labels, etc. Entries must reach Atlantic City between April 15 and May 9. Details may be obtained by writing to Francis H. Redewill, M. D., secretary, American Physicians Art Association, Flood Building, San Francisco, Calif.

Ohio's Needs in Mental Hygiene . . .

Minimum Requirements for Progressive Program Outlined by Director Of Welfare; Needs in Penology and Juvenile Research Also Included

IN order to raise the position of the State of Ohio in the field of mental hygiene and penology from near the bottom of the list of the several states to a much more improved position, and to maintain the present favorable status in caring for unfortunate children, the State Department of Public Welfare has formulated the following objectives for its immediate goal, according to a release from Judge J. H. Lamneck, department director:

1. Take initial steps that will eventually make Ohio mental hospitals, "hospitals in fact as well as in name"; fully activate the division of mental hygiene; and develop a proper educational research and preventive program on the subject of mental illness.

2. A more humane, practical, and economic system for the confinement, classification, segregation and rehabilitation of prisoners sentenced by the criminal courts so as to give maximum security to the public, and to prevent repeated offenses.

3. Provide the Bureau of Juvenile Research now established by law with additional facilities so it can function as originally intended, viz., as a receiving center where children committed by the juvenile courts to the state can be examined, observed and classified, and then be sent to an appropriate facility to carry out the order of the court making the commitment.

To carry out these objectives, the department recommends the following as a minimum:

I. MENTAL HYGIENE DIVISION

(1) A separate and increased budget for the division amounting to several millions of dollars per year to enable it and the institutions under its control to employ needed additional professional and other help. (A large part of the increase is needed to put into operation facilities now under construction.)

(2) Enactment of legislation to provide funds for the study and prevention of mental illness. In order to properly finance an adequate Educational Research and Prevention Program, department authorities will recommend to the Legislature, enactment of a law to provide that persons who are financially able to pay for treatment in state mental institutions, shall be charged the actual cost of maintenance instead of the present maximum of $5.50 per week and that the actual amounts paid in over the present maximum be paid into a rotary fund to the credit of the Division of Mental Hygiene to be used for research, education and prevention.

(3) Additions and betterments to existing mental institutions other than Lima State Hospital, the request for which is covered under the Correctional Division, totaling $23,500,000. (The amounts requested by the superintendents of mental hospitals for the next biennium totaled approximately $55,000,000, for other than the Lima State Hospital.)

(4) An appropriation of $1,000,000 to acquire a site and to build a Receiving Hospital at Portsmouth. (A request for a Receiving Hospital at Cincinnati is included in the preceding Item 3.)

II. DIVISION OF CORRECTIONS

(1) The enactment of enabling legislation to provide for a central receiving center to which all offenders sentenced under the criminal laws of the State would be sent for observation, classification, and segregation. (Such a center is in full operation at Ohio Penitentiary at the present time, but it is of little use to the Department because of lack of facilities for segregation.)

(2) The enactment of enabling legislation that would authorize the receiving center to assign an offender to an appropriate institution, there to be confined, cared for, treated, trained, and rehabilitated until released as provided by law under the order of the court sentencing the offender.

(3) The retention of the Ohio Penitentiary as the receiving center, and also as a maximum security prison to house long-term and other criminals who are beyond rehabilitation with a capacity not to exceed 2,400 prisoners. (The normal capacity of Ohio Penitentiary is 2,400, although at the present time it is housing 4,100 by putting as high as four prisoners in the same cell. Adequate facilities are not available to segregate psychopathic and sexual perverts and other hardened criminals from those for whom there would be hope of social rehabilitation, under the right conditions. The penitentiary only has facilities for employing 2,400 prisoners at the present time.)

(4) The conversion of the Ohio State Reformatory at Mansfield into an intermediate security penitentiary for criminals of all ages, at its present capacity of 2,000. "While this institution is called a reformatory, it is only so in name

because it is nothing more than a penitentiary in structure and should be used as such."

(5) The retention of the London Prison Farm for that class of prisoners who can be restrained with a minimum of security with a capacity of approximately 2,500. (The present population is approximately 1,700.)

(6) The erection of a new reformatory for young offenders which would be a reformatory in fact as well as in name, on land now owned by the State, at an initial cost of approximately $6,500,000.

(7) The erection of facilities at the Lima State Hospital which is now used for criminals who are mentally ill, as follows: (a) A new women's unit of 250 beds; (b) A new unit for psychopathic offenders; and (c) A new unit for defective delinquents.

All three of these units to cost approximately $6,500,000. "If Ohio is to take adequate steps to protect its citizens from repeated offense by the feeble-minded, psychopaths, and other offenders whose mentality is sub-normal, these three units are absolutely essential."

(8) The development of an adequate parole system that has for its primary objective, the giving of assistance to a parolee to enable him to abstain from a fresh offense.

(9) Additions and betterments to existing state penal institutions, approximately $3,500,000. (The amount requested by the superintendents of such institutions for the next biennium was approximately $5,000,000.)

III. DIVISION OF JUVENILE RESEARCH, CLASSIFICATION, AND TRAINING

(1) The enactment of legislation to enable the Bureau of Juvenile Research to perform its functions now provided by law under which all juveniles committed by Juvenile Courts to the state would be sent to the central receiving center where they would be observed and classified and then sent to an appropriate facility.

(2) The building of new facilities to enable the Bureau of Juvenile Research to function properly, approximating $500,000 in addition to current needs.

(3) Additions and betterments to existing facilities at the Boys' Industrial School, the Girls' Industrial School, and at the Marion project now under development, approximating $3,500,000.

According to Judge Lamneck, the total amount requested by the superintendents of the various institutions within the Department of Public Welfare and in the new facilities necessary to improve Ohio's position in the field of mental hygiene and penology totaled approximately $85,000,000. "While all requests that have been made have considerable merit, we realize the State is in no position financially to undertake such a burden. The amounts set forth herein for additions and betterments approximate $45,000,000," he stated.

"All of the recommendations made in the foregoing statement are consistent with the Sherrill Report, the recommendations of the Post-War Planning Commission, the Ohio Mental Hygiene Association, and other civic and welfare groups. Arthur L. Glattke, Chief of the Division of Corrections, concurs with me in considering the foregoing as an absolute minimum," Judge Lamneck concluded.

Activities of the Editor

Dr. Jonathan Forman, Editor of *The Journal*, was the after-dinner speaker at the winter meeting of the Ohio Parks Association where he spoke on the subject, "Health and Vigor From Out-Door Recreation and Good Food." He emphasized the opportunity that park managers have to teach youth the importance of soil and water conservation. Dr. Forman is vice-president of Friends of the Land. Other recent activities in which he took part include the following:

He took part in the annual dinner meeting of the Columbus Milk Council.

He addressed a recent meeting of the Columbus Society of Medical Technicians on the subject, "Modern Trends in Medical Care."

He made an inspection trip into the Wayne Federal Forests in south-east Ohio.

At a meeting of the Parent-Teachers Association of the St. Mary Magdeline Parish in Columbus, he spoke on "What Soil and Water Conservation Can Mean to Your Children."

He presided at the February 25 meeting of the Franklin County Historical Society of which he is the first chairman. Dr. Forman also is professor of the history of medicine at Ohio State University.

On February 28, Dr. Forman spoke to the downtown Kiwanis Club of Columbus on the history of medicine in Ohio. He pointed out factors that have been and are undermining our Republic and illustrated how they work by how medicine serves the people.

He addressed the Ohio Rural Health Council on the theme of the importance of nutrition as a factor in rural health. Guests at this meeting were members of the Columbus Chapter of Friends of the Land.

He addressed the North End Garden Club of Columbus on the subject, "The Living Soil," and on three successive evenings spoke before the teachers of the Bexley public schools, the Woodland Garden Club of Columbus, and the Montrose School (Bexley) Parent-Teachers Association.

A workshop on the education of the public about the matter of its health, is being arranged by Dr. Forman for the 19th Annual Institute for Education by Radio, which will be held in Columbus, May 5-8.

On the Congressional Front . . .

General Picture of Situation in Washington on Medical-Health Bills Presented in Gross News Letter; Action Soon on Measures Expected

BECAUSE of the time lag between the day when *The Journal* goes to press and the date when it reaches its readers, it is difficult for it to do a comprehensive job of reporting events in the U. S. Congress where the status of bills can change almost overnight.

Therefore *The Journal* has to confine its reporting of developments at Washington largely to stories which will present a picture of the general situation, with little specific comment on specific pieces of legislation.

The following excerpts are from *Washington Report on the Medical Sciences*, dated March 21, a weekly news letter edited and produced by Mr. Gerald Gross, a former newspaper man. These comments are reproduced by *The Journal* because it believes they size up the situation in Washington in a general way but contain sufficient spot news to give readers a good idea of what is taking place or likely to take place in the immediate future:

* * *

Both houses of Congress began to move last week on the volume of public health and medical legislation, still increasing, with which they are confronted. Friday afternoon the Senate passed, without dissent, the National Science Foundation bill, which brings that much closer the inception of Federal medical scholarships and fellowships and coordination of medical research.

On the same day Senate Labor and Public Welfare Committee approved a school health services bill possessing broad implications, since it provides for subsidized treatment—as well as diagnostic and preventive care—of medical and dental conditions in children aged from 5 to 17. On the House side of Capitol Hill, the health subcommittee of Interstate and Foreign Commerce Committee scheduled public hearings for March 30, 31 and April 1 on National Science Foundation, presaging early enactment of that measure. Meantime, Senators Taft, Smith (N. J.), Murray, Pepper and Hill were applying finishing touches, preparatory to introduction, of their various national health bills.

ANOTHER TAFT BILL PROMISED

Three weeks ago your correspondent wrote that the Taft-Smith bill might be dropped into the hopper the first week in March. Drafting of the measure took longer than planned but the interval which remains until it is introduced may now be counted in days. Look for its major provisions to be: (1) Authorization of a $1,250,000,000 5-year program for assistance of the medically indigent; (2) joint Federal-State support of school health services; (3) expansion of the Hill-Burton Act; (4) strengthening of local public health units; (5) financial aid to medical and dental schools and possibly a special provision for scholarships; (6) establishment of a National Health Agency, absorbing all of U. S. Public Health Service and those branches of Food and Drug Administration, Children's Bureau and Social Security Administration whose functions are primarily of public health nature.

WORK ON NEW W-M-D MEASURE

Slightly more distant into the future is introduction of an overhauled Murray-Wagner-Dingell bill. Still in the drafting stage, the revamped version of S. 5 will be timed to coincide or come immediately after President Truman's transmittal to Congress of his special message again urging passage of compulsory health insurance. This is expected in a week or 10 days.

Here again will be an omnibus bill, not too much unlike the Republican plan save that it does call for national insurance and does not set up a new Federal health agency. WRMS No. 85 predicted that the Administration's replacement for S. 5 would "provide for Federal aid to medical education (also nursing and dental), public health services expansion, construction of more hospitals and more subsidization of medical research." That still stands and one may also look for inclusion of benefits for health cooperatives and rural health services.

NATIONAL SCHOOL HEALTH BILL

Some quarters were inclined last week to interpret the appointment of a special Senate subcommittee to handle hospital expansion (S. 614) and local public health units (S. 522) legislation as a snub to the standing committee on health headed by Senator Murray. This was done, however, solely to prevent those two noncontroversial measures from becoming engulfed, and their enactment consequently delayed, by the battle over health insurance which will come during public hearings to be conducted by the Murray subcommittee.

Here are the main points of the "National School Health Services Act of 1949," as this important bill will be known which is to be introduced in the Senate—under bipartisan sponsorship—with a recommendation by the Labor and Public Welfare Committee that it be enacted into law. It enunciates a national policy to aid

the several states in provision of preventive, diagnostic and therapeutic services to children enrolled in private and parochial, as well as public, schools requiring same. An annual Federal appropriation of $35,000,000 is authorized, with the participating states obligated to contribute varying shares dependent in size upon per capita income and child population. A state may, if it desires, make **all** children eligible for **treatment** of "physical and mental defects" without cost to the family. Or this privilege may be reserved for children in medically indigent families. To get around laws of certain states that prohibit distribution of tax-raised funds to non-public institutions, such as parochial and private schools, the bill provides that payments may be made by the Federal Security Administrator.

The bill makes it clear that "the qualified health, medical, dental, hospital and other related facilities already established in the state," and particularly in the local community, shall be utilized as far as possible. States also are directed to cooperate with private organizations in the medical and allied fields in carrying out the program. At the same time the bill was approved by Senate Labor and Public Welfare Committee, the same group voted to report favorably the $300,000,000 aid-to-education bill, to which the school health measure will be an appendage in the trip toward Congressional enactment and presidential approval.

Dr. Toomey To Be Honored

A portrait of Dr. John A. Toomey is being painted by Mr. Rolf Stoll at the invitation of a small committee of Dr. Toomey's friends and associates in Cleveland. Those who are interested in joining with the committee in so honoring Dr. Toomey are invited to make their checks payable to Mrs. Marguerite Eisenmann, secretary, Babies and Childrens Hospital, Room 628, Cleveland 6. A photographic copy of the portrait will be sent to each of the contributors. If more money is collected than is necessary for the portrait, the balance can be used in showing Dr. Toomey additional honors, a member of the committee reported.

Add Device at Juvenile Bureau

An electro-encelphalograph was unveiled in March at the Bureau of Juvenile Research, Columbus. The device is a complex piece of equipment which makes a written record of the electrical currents given off by the human brain. Present for the occasion were officials of the State Department of Public Welfare and The Ohio Society for Crippled Children. The latter organization presented the equipment to the Bureau as an aid in testing children for brain damage or abnormalities.

Do You Know? . . .

Dr. Richard L. Meiling, Columbus, represented the Committee on National Emergency Medical Service of the Ohio State Medical Association at the semi-annual meeting of the Council on National Emergency Medical Service of the American Medical Association, March 21, at Chicago. He spoke on "Medical Activities of the National Security Resources Board." Dr. Meiling is a member of the Council, also the Armed Forces Medical Advisory Committee to the Office of Secretary of Defense, Washington, D. C.

* * *

The National Advisory Mental Health Council has awarded grants totaling $1,500,000 to 42 medical schools for expanding or developing undergraduate training in psychiatry. Included are the Ohio State University College of Medicine and Western Reserve University School of Medicine, which will each receive, through the United States Public Health Service, total grants of $37,500 for three years, beginning with the 1949-50 school year.

* * *

The Seaview Country Club has been chosen for the thirty-third tournament of the American Medical Golfing Association scheduled for Monday, June 6, during the A. M. A. session in Atlantic City. Applications for A. M. G. A. Fellowship are available by writing Secretary Bill Burns, 2020 Olds Tower, Lansing 8, Michigan.

* * *

Salaries of hospital employees increased 10 per cent, and hours per week decreased by one hour, in 1948 over 1947, according to the fourth annual nation-wide study of hospital salaries made by the American Hospital Association.

* * *

Rear Admiral Clifford A. Swanson, Surgeon General of the U. S. Navy, recently stated that more than 17,000 cases of smallpox had occurred in Japan during the first year of occupation. During the past six months the number has been reduced to 21, as a result of the mass vaccination of 78,000,000 of the 80,000,000 Japanese. Typhoid fever has been reduced to one-fourth the prewar number of cases.

* * *

According to the *Statistical Bulletin* of the Metropolitan Life Insurance Company, the infant mortality rate in the United States is now about 32 per 1,000 live births, or less than one-half of the rate recorded only 20 years ago. In the past two decades, the decline in the death rate from pneumonia and influenza amounted to about 70 per cent, for diarrhea and enteritis 80 per cent and for the principal communicable diseases of childhood about 90 per cent.

Rural Health Activities . . .

Annual State Conference Held in Columbus; Group Endorses Report of Ohio Committee on Public Health; Two District Conferences Also Held

THE Fifth Annual State Conference on Rural Health, held at the Southern Hotel in Columbus February 28 and March 1 dealt with the practical aspects of solving problems concerned with animal diseases affecting man, diet, and health, and the essentials of an effective public health program.

The conference is sponsored annually by the Ohio Rural Health Council, which comprises representatives of the farm organizations, the Agricultural Extension Service, professional organizations, including the Ohio State Medical Association, and others.

CONFERENCE SPEAKERS

Conference speakers and their subjects were: Floyd Lower, Columbiana County Agricultural Agent, "Health Organization and Program in Columbiana County"; James H. Steele, D. V. M., U. S. Public Health Service, Atlanta, "Animal Diseases Affecting Man"; Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal*, "Diet and Health."

Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, "Improving the Public Health Setup in Ohio"; Dr. John D. Porterfield, director of The Ohio Department of Health, "Progress in Health Districts"; A. J. Borowski, Dr. P. H., Ohio Department of Health, "Progress in Hospital Building"; H. W. Nisonger, director, Bureau of Special and Adult Education, Ohio State University, "The National Health Assembly"; and Dr. Carl E. Buck, Department of Health, University of Michigan, "Essentials of an Effective Local Public Health Program."

DISCUSSANTS

The following physicians served in a resource capacity to the four discussion groups into which the conference was divided to consider the subjects outlined by the speakers: Dr. J. Martin Byers, Greenfield, and Dr. Edmond K. Yantes, Wilmington, members of the Ohio State Medical Association's Committee on Rural Health, Dr. O. W. Jepsen, Canal Winchester, and Dr. Porterfield.

Mr. Nelson, and Mr. Hart F. Page, secretary to the Ohio State Medical Association Committee on Rural Health, served as discussion group leaders.

Prior to adjournment the conference voted endorsement of the report of the Ohio Committee on Public Health, which is entitled, "Ohio Can Have Better Health Service." This report constitutes an investigation of the financing of the Ohio Department of Health, and recommends, among other things, that the Ohio General Assembly appropriate sufficient funds to permit the Department to carry on the work required of it by State statutes.

DISTRICT CONFERENCES

Two district conferences, also sponsored by the Ohio Rural Health Council, were held during February. The Northwestern Ohio conference was held February 2 at the Main Auditorium of Bowling Green State University.

Speakers and subjects were as follows: Sewall O. Milliken, extension specialist in rural health, Ohio State University, "Brief History and Purpose of the Ohio Rural Health Council"; Dr. Harry Wain, Richland County Health Commissioner, "Functions and Trends in Local Health Departments;" and Dr. Borowski, "Public Health Needs in Rural Areas in Ohio."

The Southeastern Ohio conference was held at the Chemistry Auditorium, Athens University. Speakers were: Guy Dowdy, secretary of the Ohio Rural Health Council, who outlined the purposes of that organization; Dr. Wain, who discussed local health department activities; Mr. Nelson, Dr. Porterfield, and Mr. Milliken. Mr. Page represented the Association's Committee on Rural Health at the district meetings.

Congress of Physical Medicine

The American Congress of Physical Medicine will hold its 27th annual scientific clinical session September 6-10 at the Netherland Plaza Hotel, Cincinnati. All sessions will be open to members of the American Medical Association.

In addition, to scientific sessions, the annual instruction courses will be held September 6-9. These courses will be offered in two groups. One set will be limited to physicians. Another set will be open to physicians and to physical therapy technicians who are registered with the American Registry of Physical Therapy Technicians. Full information may be obtained from the Congress at 30 N. Michigan Ave., Chicago 2.

Industrial Medicine Fellowship

Under the joint sponsorship of the New Departure Division, General Motors Corporation, and the Yale Institute of Occupational Medicine and Hygiene, a one-year clinical fellowship is offered to a qualified candidate who wishes to pursue a graduate course of instruction in occupational medicine. The course will begin July 1. Additional information may be had from the Yale Institute, New Haven, Conn.

Doctors for Armed Forces . . .

State Association Requests that Appeal for Volunteers Among Draft-Age Doctors Be Followed Up by Committees of County Societies

A PROGRAM, designed to lay before each doctor in the State within draft age the need for additional medical officers in the armed forces, has been approved by The Council of the Ohio State Medical Association. A letter by President Brindley has been sent to County Medical Societies for consideration and action.

The action by The Council, at its meeting on February 27, is part of the medical profession's efforts to fill the present needs of the military forces with volunteers.

Following approval by the House of Delegates of the American Medical Association, Dr. R. L. Sensenich, President of the national organization, appealed to all doctors of medicine under the age of 26, urging them to offer their services in the armed forces. According to a report made in early February, of the 991 doctors who replied to the letter, only 508 requested applications for commissions in the Medical Corps of the Army, Air Force or Navy.

PERSONAL CONTACT

The Ohio State Medical Association has been furnished a list showing names of those doctors of the State who have requested applications for commissions, and 324 names of those have not responded to the appeal. The names of those who have not replied to Dr. Sensenich's appeal are being distributed to respective medical societies of counties in which the doctors reside, with a request that committees personally contact each one of the young doctors.

The office of the Secretary of Defense recently made public a report of the need of additional officers and renewed its appeal for volunteers.

"By July of this year," the statement reveals, "we will have lost almost one-third of the physicians and dentists who are now in the Armed Forces. An overwhelming majority of these are former V-12 and A. S. T. P. students whose tours of duty have been completed.

SHORTAGE ACUTE

"This new loss means that the Armed Forces will not have enough professional men to give necessary medical services to the almost 1,700,000 men and women who are serving their country.

"There are 15,000 young physicians and dentists in America today who were deferred from the draft and excused from combat in order to complete their professional education," the statement continues. "Of this group, 8,000 received all or part of their professional training at government expense—the remaining 7,000 paid for their own education, but were excused from the draft and combat service.

"By the end of July, 1949, we will be short about 1,600 physicians and about 1,160 dentists. By next December, this shortage will grow to 2,000 physicians and 1,400 dentists.

"Only some dramatic event, or series of events, which will cost us dearly in health and higher death rates will point up the situation," the Under Secretary of the Army stated.

TRYING TO AVOID DRAFT

The Secretary of Defense's statement concludes with the statement that if the program to secure volunteers fails, then the Military Establishment must resort to more drastic means, such as holding men in the service beyond their normal time or asking Congress to pass a special draft law which would encompass physicians and dentists beyond the present draft law age of 26.

Rheumatic Diseases Congress

The Seventh International Congress on Rheumatic Diseases will be conducted by the American Rheumatism Association under the auspices of the International League against Rheumatism in New York City, May 30-June 3. Among members of the American Committee of the League and Committee on Arrangements are Dr. Edwin P. Jordan and Dr. Robert M. Stecher of Cleveland.

Women Now Outnumber Men

The ratio of males to females in the United States has been steadily decreasing since the early years of the century. In 1910, after a decade of heavy immigration to our shores, there were 1,060 males to every 1,000 females in our population. By the time of the 1940 census, however, the ratio was down to 1,007 per 1,000; the excess of males in absolute numbers then amounted to only about 450,000.

This excess has since been erased, and has actually been converted into a deficit. For the first time in our history, there are fewer males than females in the population. In 1947, the deficit was more than one-half million and the sex ratio was about 992 males per 1,000 females, even when men in the armed forces overseas were counted.

This shift in the sex ratio of the population between 1910 and 1947 was country-wide. The largest drop occurred in the west.—*Metropolitan Life Insurance Bulletin.*

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

LET'S LOOK AT THE FACTS

There are a few groups and individuals who are using every possible excuse to throw barbs at the A. M. A. for having had the courage to face national issues through its educational campaign to the public.

They have pointed to a vote taken in the New York County Medical Society refusing to endorse the A. M. A. $25.00 assessment. They have charged the A. M. A. with having circulated the so-called Dan Gilbert letter which is said to have raised racial and religious issues.

Now let's look at the facts.

The New York County Medical Society has a membership of about 6,000. The vote on the A. M. A. assessment was 333 for and 432 against. In other words, approximately one-eighth of the total membership cast a vote—not a representative vote in anybody's book.

The Dan Gilbert letter was circulated by the National Physicians Committee, not by the A. M. A. In fact, the A. M. A. publicly has stated that "the Gilbert letter was sent without the knowledge of any official of the A. M. A., that every official of the A. M. A. joins in condemning the letter as an expression of medical opinion in this country and that the A. M. A. does not require allies of doubtful repute in its campaign for the maintenance of a high quality of medical care and for freedom in medicine in this country."

These facts also should be added: Ohio State Medical Association has never by action of any official body of the Association endorsed the National Physicians Committee.

The Ohio State Medical Association several years ago issued a 25-Point Health Program which is constructive and progressive from beginning to end and it has actively supported all of those 25 points.

The Ohio State Medical Association, through its Council, has endorsed the new 12-Point Program of the A. M. A. and pledged its active support to that program.

The Ohio State Medical Association has a record of having supported sound, constructive legislative proposals, state and national.

There are many physicians who heretofore have contributed to the National Physicians Committee who believe now that the N. P. C. should be abandoned and that allied groups who desire to engage in an educational campaign, to parallel that of the A. M. A. should do so through their own national organizations, with proper coordination with the activities of the A. M. A. With that point of view, we are in complete agreement.

GOOD PUBLIC RELATIONS IN TUSCARAWAS COUNTY

Recently the Public Relations Committee of the Tuscarawas County Medical Society issued a report, based on a survey and study of the medical services in that county. During the study, the committee publicly requested the people of the community to send in criticisms. The committee's report was published in the local newspapers.

Because this was a unique method of bringing about a better understanding between the physicians of Tuscarawas County and the people of the community, we believe the report of the committee will be of interest and value to other county medical societies; may stimulate similar action elsewhere. Therefore, it is published in full as follows:

The Committee on Public Relations of the Tuscarawas County Medical Society has concluded a survey of medical services in the County with the following findings:

At this time there are fifty-four physicians serving Tuscarawas County which has a total population of approximately 60,000. The geographical distribution of physicians is such that practically every family in the County has a doctor easily accessible for his needs and, on the outer edges of the County, there is over-lapping of service from the adjoining counties. The general conclusion is that this County is amply provided with physicians well located to cover the entire territory.

Th request for criticism of the present service, published two weeks ago in our local papers, brought interesting and informative results. There were several complimentary letters commending our efforts as well as those offering criticism. One organization pointed out the difficulties in getting a doctor on Wednesday afternoons and on Sundays and asked that this condition be remedied. The Committee has tried to set up a program to meet this situation by asking the public to proceed in the following manner:

> Call your own physician first. He will try to keep his phone covered and if he is not available, someone there will assist you in getting another doctor.
>
> If you have a real emergency and cannot wait for your doctor, take the patient to the local hospital in your community where medical service is available at all hours.
>
> To answer your needs and to make this

plan workable, all active physicians have agreed to keep their phones covered as many hours as possible.

In return, the profession is asking the public to remember that the doctor is a human being and is subject to the ills that flesh is heir to. He cannot continue twenty-four hour service indefinitely and remain long in your service. There are a great many persons in our social order who believe that eight hours work is all any man should do in a day and who refuse to work longer. Doctors, however, have never adopted this policy even though their work goes on a great many hours longer and probably is more exacting and exhausting. No one should become angry when told the doctor cannot help him at the time he is summoned. Perhaps he has been on duty for many hours which makes it impossible for him to continue. The public should understand this and not expect an explanation. In those rare cases where time is the saving element, prompt service can and will be given if the above plan is followed.

It was pointed out that in a great many cases there is a question of the integrity of the individual requiring service. It seems that the man who seldom pays his bills is our severest critic and cries the loudest that he is unable to obtain the services of a doctor when needed. To cite a case in point, there is a family which has six children; a different doctor was called for each birth and not one of these ever received as much as a thank you for his services, yet all were maligned for failing to continue to give free service. This type we have with us always and they condemn us indiscriminately.

On the other hand, the thoughtful person has a different viewpoint. He realizes that great social change has taken place during the last few years and this has changed the work of the physician. Today your doctor would spend half his time on records and reports were he unable to have office help. The many reports are mandatory and rather than go to jail, he must do them. Recently a request was made by a patient to a doctor to give him a record of the number of office calls he had made during the past 31 years to enable him to show service-connected disability from World War I. This alone would require innumerable hours of work.

The patient is unaware of the complexity of the doctor's business. Each day more and more routine paper work is forced on him and gradually the practice is changing. He is no longer the family physician of old. He is business man, tax expert, employer and statistics builder as well as a practitioner of medicine. Further, he must keep abreast with the progress of modern medicine which requires hours of reading and study. He is asked to take part in many public enterprises as well as assist the many organizations operating for the betterment of public health such as Cancer Clinics, Infantile Paralysis, Tuberculosis and Heart Disease. Day by day the burden grows. Each time he hires an employee, his paper work increases because of this fact alone. As an employer, he must make reports on payroll deductions for social security and income tax. His office expenses increase accordingly and this in turn is felt by those desiring medical attention.

The doctor does his best and each night hopes and prays that socialized medicine with its many directives, orders and reports will never come any closer and that he will have more time to give to his patients and be less encumbered with those things which have nothing to do with treating the sick.

Burrell Russell, M. D., Chairman
Wm. E. Hudson, M. D.
E. C. Davis, Jr., M. D.
B. Pilloff, M. D.
J. S. Adler, M. D.
Mary E. Aplin, M. D.

SOMETHING FOR SOME OLDSTERS TO THINK ABOUT

"I am enclosing a check for $10.00 to be used in the American Medical Association campaign against socialized medicine. I am at present a resident in training, have a family of four to support, and feel that this is all I can contribute at this time."

Thus read a letter received at the Columbus Office recently, the spirit of which deserves a great deal more praise and commendation than words will express. Others like this youngster have given, also.

There are some physicians with established practices who should take a lesson from the young man in training, who wrote the letter quoted.

"OHIO PINCHES HEALTH PENNIES"

In the March issue of *The Journal* appeared an abstract of a report of the Ohio Committee on Public Health, of which the Ohio State Medical Association is a member, calling attention to the financial problems of the Ohio Department of Health.

On March 7, the *Cleveland News* published the following editorial, entitled, "Ohio Pinches Health Pennies," which lays the situation on the line in no uncertain terms:

"It is humiliating knowledge that the proud state of Ohio is 47th in the 48 states in spending its own funds for public health.

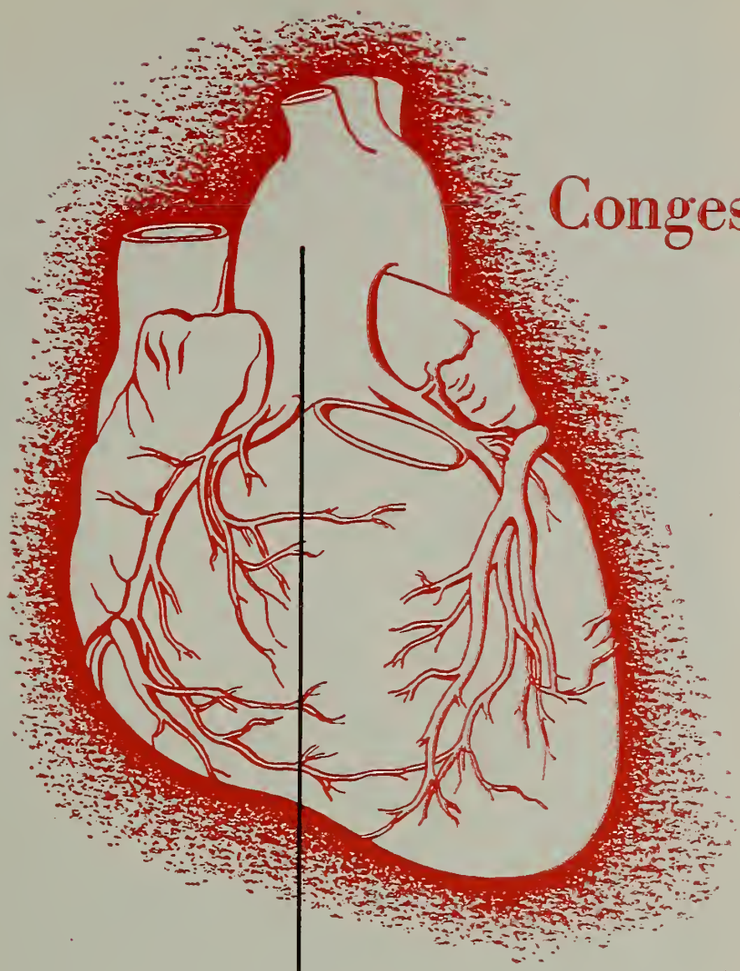
"Ohio draws almost a million dollars annually in federal subsidy designated for aid to local health services. It bootlegs those funds to pay operating expenses of the state health department, which should be a charge upon the state itself.

"The result, as revealed last week in *The News*, is that two-thirds of the state's population receives sub-standard health protection because local communities are deprived of adequate financial assistance.

"Now a real demand for reform is being sponsored by 12 state organizations, who will petition Governor Lausche and the Legislature for decent appropriations for state health purposes.

"This is a campaign without political implications. The organizations have no partisan ties. They represent a cross-section including farmers, labor unions, medical and health associations and women's clubs.

"They demand merely that Ohio act to end a



Congestive Heart Failure...

"The most striking effects were seen in cases of hypertensive heart failure. . . . There is a rapid fall in the raised right auricular pressure with a conspicuous increase in the output of the heart."[1]

SEARLE

AMINOPHYLLIN*

—improves cardiac failure by effecting an improved heart action with increased blood flow, and eliminating edema fluids by the renal route.

Searle Aminophyllin is indicated in paroxysmal dyspnea, bronchial asthma, Cheyne-Stokes respiration and selected cardiac cases.

ORAL—PARENTERAL—RECTAL DOSAGE FORMS

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

**Searle Aminophyllin contains at least 80% of anhydrous theophylline. G. D. Searle & Co., Chicago 80, Illinois.*

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Howarth, S.; McMichael, J., and Sharpey-Schafer, E. P.: The Circulatory Action of Theophylline Ethylene Diamine, Clin. Sc. 6:125 (July 17) 1947.

shockingly bad health record in preventable diseases."

The record referred to is not going to be corrected merely through the issuance of a report and the publication of editorials, regardless of how good they may be.

The solution can come about only through concerted demands and action on the part of the people of Ohio who in the end are the ones chiefly concerned.

By action, we mean telling the story to officials of the executive and legislative branches of the government, recommending that something be done to correct the situation now.

MEETING ONE OF THE PUBLIC'S PET PEEVES

Physicians in Fayette County have worked out an arrangement whereby one physician will be on emergency call every night, with an alternate ready should unusual emergencies develop.

The same action should be taken in other areas. Through tangible action of this kind, physicians will be taking a big step toward eliminating one of the public complaints which is heard repeatedly—and with some justification. It is one of those series of complaints which, when added up, give thoughtless people the idea that a big national program may be utopia—which of course it won't.

AKRON NEWSPAPER COMMENDS AUXILIARY HEALTH DAY

The local newspaper in a community often is an accurate barometer of public interest. Judging by newspaper comments alone, the Health Day Exhibit promoted by the Woman's Auxiliary to the Summit County Medical Society in Akron, February 4 and 5, was well worth the great amount of effort and preparation that went into it.

The Akron Beacon Journal devoted more than 115 column-inches of space to the exhibit and editorially gave the ladies quite a pat on the back. Among the approximately 3,000 visitors to the exhibit were a number who specifically mentioned the newspaper write-ups. *The Akron Beacon Journal's* commending editorial is as follows:

'FOR GOOD HEALTH'

"Too many women's auxiliaries to professional organizations are merely formed for the purpose of giving wives a chance to get together and gossip.

"An exception, however, is the auxiliary to the Summit County Medical Society. Its members are as interested as their doctor husbands are in the subject of health.

"As a public service, the auxiliary has arranged for an exhibit which will provide much interesting and helpful information about ways in which the health of individuals and the community may be improved.

"The exhibit will be held Friday and Saturday at the M. O'Neil Co. auditorium with 38 public and private agencies participating.

"No subject has a more universal appeal. Good health is a matter of deep concern to all of us—never fully appreciated until it turns into bad health. The exhibit is one that will be worth seeing. The auxiliary deserves the thanks of the community for promoting it."

MORE MEETINGS ON MEDICAL ECONOMICS NEEDED

At a recent meeting in a certain part of Ohio, attended by a considerable number of young physicians, the following opinion was voiced:

"We should have more medical society programs devoted to medical economics and politics and less on the scientific side. We can read plenty of scientific information in the various medical publications."

To which we append a loud "Amen." Scientific programs have their place but they should be spaced to permit more programs on the subjects cited above. One thing program committees should remember is that sandwiching in a speaker on some medical-economic subject between coffee and a name speaker with a scientific subject, giving the first speaker a time limit of six minutes, is a real waste of time and effort. Building the entire program around the economic subjects which need discussing is the only way to do the job and do it properly.

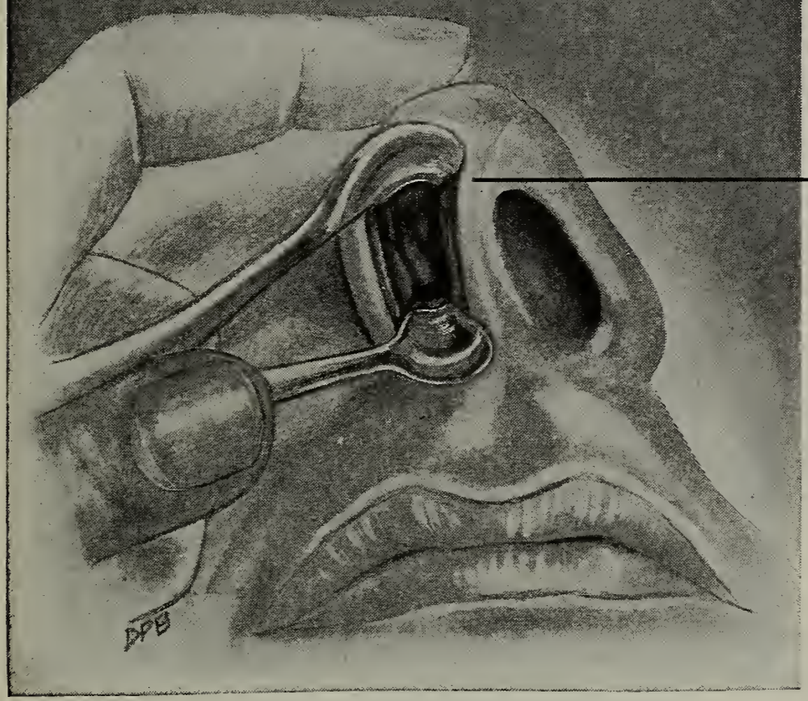
More programs of that kind are badly needed in every county.

MR. EWING'S COMPARISON IS PURE BUNK

In one of his numerous speeches promoting compulsory sickness insurance, Federal Security Administrator Oscar Ewing made the weird statement that his plan is no more socialized medicine than fire insurance is "socialized insurance." Mr. Ewing inadvertently, or otherwise, overlooked several very important points in making this comparison.

John Q. Public is not compelled to buy fire insurance. He would be compelled to buy Mr. Ewing's brand of medical protection. Writing of fire insurance is not carried on under the supervision of politicians A fire insurance contract is standardized and sells at a stipulated price for standard amounts of coverage. Medical care is anything but standardized, each procedure being designed to meet the case of the particular individual if properly carried out. Fire insurance rates are set to meet certain basic risks. Medical coverage cannot be standardized to that extent, especially when it attempts to provide complete coverage. Even a governmental plan

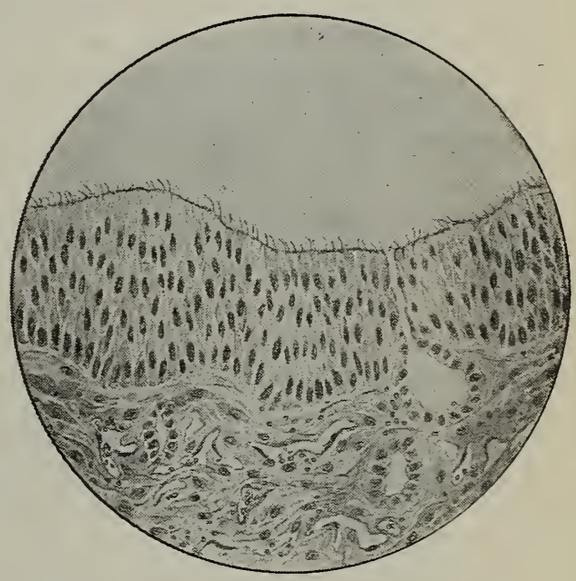
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has to be subsidized from general tax funds, experiences in other countries have revealed.

Mr. Ewing again let his foot slip. The folks will want to analyze his statements pretty carefully before they accept them as real words of wisdom.

A SYMPATHETIC EAR MAY MEAN MUCH TO PATIENT

"They (the patients) want a sympathetic ear, an understanding mind and time enough to tell their story. If we can make them feel that their problems are our problems, and that they can count on us through thick and thin, then I do not feel that we need worry too much about the type of medical practice in the future.

"If our patients feel, however, that we are always wanting to get away to the best homes and the best clubs in town and that they, the patients, are only a means to that end, then our present type of medical practice is nearing its end . . ."

The above statements were made by Dr. George L. King in an article in the *Stark County Medical Society Bulletin.* He put his finger on an important point—a weakness in the relationship between too many physicians and their patients.

LIKE CHARITY, PUBLIC RELATIONS BEGINS AT HOME

"News" has been defined by one authority as that which interests people or which can be presented in such a way that it will interest people. There is scarcely a person in Ohio who doesn't know several doctors in his community either directly or indirectly. Any item in the local newspaper about doctors, therefore, is "news."

Many county medical society officers are doing an excellent job in getting a news story (perhaps only a paragraph or two) into the local newspaper each time the county society meets. Those little stories add up over a year's time.

An item reporting that Dr. Whozit spoke before the local society on some unpronounceable subject may not seem important; but that little notice carries a message to the reader. Through his mind goes the thought, "Those doctors are always trying to learn a little more about how to treat their patients."

PUBLIC RELATIONS IS JUST THE OLD 2 PLUS 2 ON A HIGH SCHOOL LEVEL

Good Public Relations may be compared to an algebraic equation in which x plus y equals the desired result, Conger Reynolds, public relations director for the Standard Oil Company of Indiana, said at the National Medical Public Relations Conference in St. Louis.

X in the equation is a good product or a worth-while service, he explained, and y is calling the attention of the people to the product or service so that they will appreciate its value.

The medical profession, he went on to say, is tops as far as having a worth-while service, but for a long time it has been at the bottom of the pile in calling the attention of the public to what it is doing.

In a democractic nation the people have a right to have both sides of the picture presented to them so that when the time comes they can make an intelligent choice. As one woman expressed it: "If some politician in Washington can press a button and cure my child's measles, I want to know about it. If my family doctor can do a better job, I want to know that, too."

THE PATIENT'S POINT OF VIEW

As has been emphasized in these columns many times the physician who enjoys really satisfactory public relations is the one who makes a special effort to consider the patient's point of view. In the end, the individual patient or groups of patients are the doctor's public and in the aggregate they are the medical profession's public.

Some excellent advice along this line is found in the following editorial in a recent issue of *The Cleveland Academy of Medicine Bulletin*:

"It may be the fault of the politicians in Washington, it may be the omnipresent Department of Internal Revenue, but whatever the cause there is certainly an increasing stress on the financial-economic side of medical practice. Does this cause us to lose sight of the better phases of our duty to our patients?

"Too frequently we hear discussed the great advantage (to us) of having patients come to the office or hospital rather than having us go to their homes. We can certainly utilize our time to best advantage this way; we can certainly increase our efficiency and our income this way; but should that always be the main consideration? Acute diseases, often contagious, certainly are not cases to be crowded in with other children or adults in a doctor's waiting room. Likewise, elderly people are often seriously upset psychologically, if uprooted from home to be handled in hospital or nursing home surroundings, no matter how much more efficient the care may be.

"The dictim now often heard that 'If a patient is too ill to come to the office, he should be admitted to the hospital' is one which certainly is engendered more by desire for efficiency on the part of the doctor than by serious consideration of what is best for the patient. It is not an universally applicable rule and the best interests of the medical profession will not be served if it is accepted as a fundamental law of practice.

"We should discuss the patient's point of view more often."

Have You an Article in this Issue?

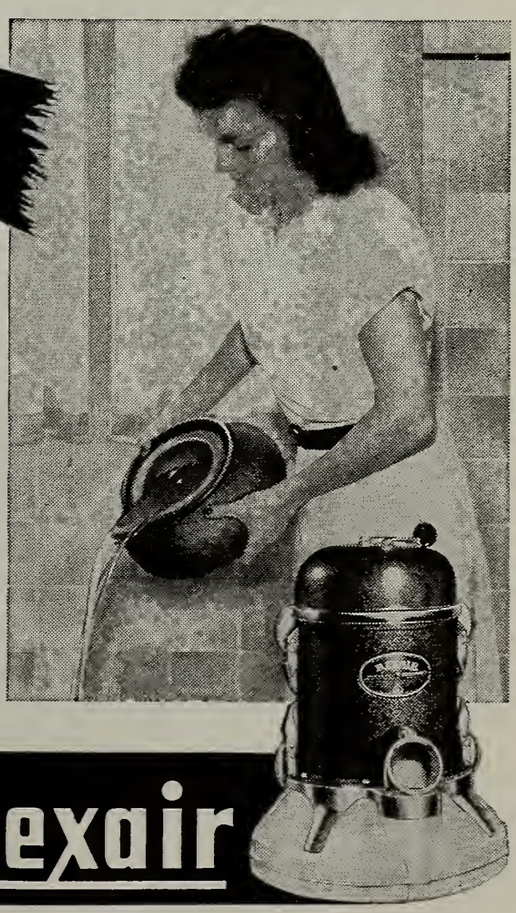
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Buckeye News Notes . . .

Akron—Dr. David J. Roberts, president of the Summit County Medical Society, spoke before the Professional Chapter of Alpha Chi Sigma, national chemical fraternity.

Akron—Dr. A. S. McCormick has been re-elected president of the Summit County Humane Society.

Ashtabula—Dr. P. J. Collander has been cited by the President of Finland as Knight of Order of the White Rose in recognition of his service to that country, principally as a vice-consul.

Bedford—Dr. Edson J. Brown, chief of the Cleveland Health Department, and Mr. Ralph Profant, an investigator for the venereal disease division of the same department, spoke on "Social Hygiene" before the Bedford Lions Club.

Bellaire—Dr. Wilbur L. Davis, Martins Ferry, was principal speaker at the J. Curtis McKelvey testimonial banquet sponsored by Masonic organizations.

Columbus—The annual alumni reunion of Alpha Kappa Kappa was held March 5 at the Athletic Club with Dr. Charles W. Harding, Worthington, acting as toastmaster.

Columbus—Dr. Charles A. Doan, Dean, and Dr. George M. Curtis, Ohio State University College of Medicine, appeared on the program of the New York Academy of Medicine in February where they spoke on the subjects medical aspects and surgical aspects of hypersplenism, respectively.

Dayton—Dr. A. B. Brower spoke on "Medical Topics" at a meeting of the Business and Professional Women's Club.

Jefferson—Dr. Thomas E. Patton, Conneaut, county health commissioner, addressed the local Rotary Club on the subject of the new restaurant code and how it is progressing.

Lakewood—Dr. Frank L. Meany, Cleveland, spoke on "Plastic Surgery" before a meeting of the Ohio University Women's Club.

Marietta—Dr. Edgar E. Northrup gave an interview discussion over radio station WMOA in connection with National Heart Week.

Marietta—Dr. Deane H. Northrup took part in panel discussion on "Socialized Medicine" before the Marietta Branch of the American Association of University Women.

Marion—Dr. Samuel Katz gave a talk on "The Heart" at a meeting of the Bethlehem Grange.

Massillon—Dr. William B. Wild, city health commissioner, opened a series of talks on venereal disease in February before a group sponsored by the Massillon Urban League.

McArthur—Dr. Richard E. Bullock spoke to 1949 graduating class of the local high school on the medical profession and allied fields.

Medina—Dr. T. R. Laughbaum, formerly of Bucyrus, is the new full-time health commissioner for Medina County.

Nelsonville—Dr. W. H. Hyde addressed the high school Parent-Teacher Association on the subject of infantile paralysis.

New Lexington—Dr. Edward V. Turner, Columbus, addressed a meeting of the Susan B. Anthony Circle Jr. of the Child Conservation League on the subject of child health problems and programs in Ohio.

New London—Dr. W. R. Roasberry, spoke before the Business and Professional Women's Club on the subject of "Cancer."

Niles—Dr. Densmore Thomas discussed "Socialized Medicine" at a meeting of the Business and Professional Women's Club, and Dr. John A. Rogers, Youngstown, spoke on "The Heart."

Norwalk—Dr. W. W. Lawrence spoke before the Local Kiwanis Club on the subject of the history and present progress in public health work.

Oxford—Dr. Hazelett A. Moore, Butler County health commissioner, spoke on the subject of health problems in the community at the local Kiwanis Club.

Painesville—Dr. H. B. Wright, Cleveland, addressed members and guests of the Good Housekeeping Club on the subject, "Socialized Medicine."

Piqua—Dr. Melvin Oosting of Dayton spoke before the Miami County Unit, American Cancer Society, reviewing cancer work at the local hospitals.

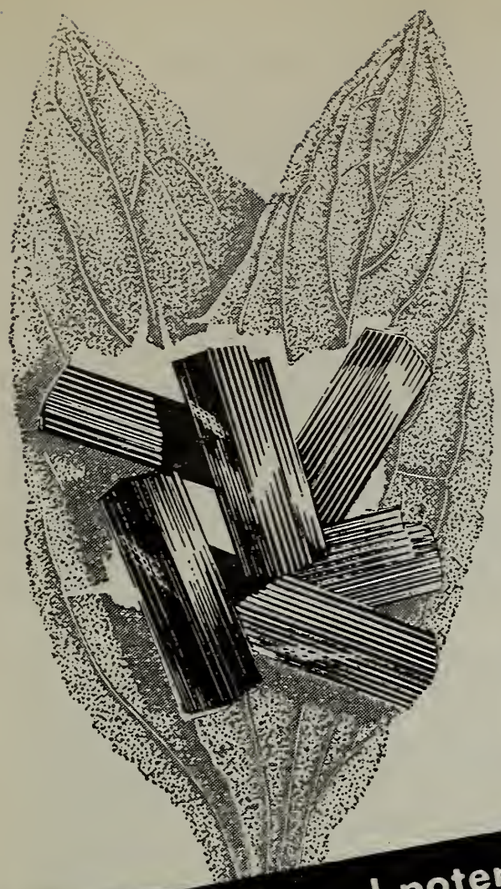
Steubenville—Dr. Fred B. Harrington addressed a meeting of the local Rotary Club on the subject of "Socialized Medicine."

Tiffin—Dr. Henry L. Abbott spoke to the Hi-Y Club on the subject of preparing for a life career.

Toledo—Dr. Dale Wilson is the new chief of staff at the Mercy Hospital. Dr. E. A. Orwig was named vice-chief and Dr. A. S. Avery, secretary-treasurer.

Troy—Dr. L. N. Lindenberger, member of the Troy Board of Health since 1920, was re-elected president of that board. Dr. G. J. Hance was chosen vice-president.

Wellston—Dr. Earl J. Levine spoke before the local Lions Club on the subject of "Government Control of Medicine."



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In Memoriam . . .

Katherine A. Astler, M. D., Cincinnati; Woman's Medical College, Cincinnati, 1889; aged 85; died February 22; former member of the Ohio State Medical Association and the American Medical Association through 1932. Dr. Astler practiced medicine in the Elmwood Place vicinity for approximately 40 years, until her retirement in 1939. She is one of a family of physicians. Her father was the late Dr. William Eckermeyer and two brothers also were doctors of medicine. Her husband was the late Dr. George H. Astler. Two physician sons survive. They are Dr. Vernon Astler, also of Cincinnati, and Dr. DeWitt G. Astler of Orlando, Fla. A grandson is a student at Temple University Medical College. Dr. Astler was a member of the Order of Eastern Star.

Edgar C. Buck, M. D., Newport, Ky.; Pulte Medical College, Cincinnati, 1891; aged 79; died February 11. Dr. Buck formerly practiced in Cincinnati and moved to Newport in 1920. Surviving are a son, two sisters and a brother.

Joseph Gibson Clemons, M. D., Mt. Orab; Starling Medical College, Columbus, 1892; aged 82; died February 22; former member of the Ohio State Medical Association and the American Medical Association through 1928. Dr. Clemons practiced medicine in Brown County and vicinity for more than 50 years. He was active in all phases of community life; was a member of the Methodist Church, the Masonic Lodge and the Odd Fellows Lodge. Surviving are his widow, two sons and a daughter.

James Allan Cross, M. D., Cleveland; Victoria University Medical Department, Coburg, Canada, 1888; aged 84; died February 27; former member of the Ohio State Medical Association and the American Medical Association through 1926. Dr. Cross practiced in Canada, England, Australia, South Africa and in Michigan before going to Cleveland in 1911. He retired in 1925. His widow survives.

Walter Edward Futrelle, M. D., Chillicothe; Jefferson Medical College, Philadelphia, 1921; aged 61; died February 10; Dr. Futrelle had been with the Veterans Administration since 1931 and in 1944 went to Chillicothe where he was chief of professional services at the Veterans' hospital. He was a veteran of both World Wars, and was a member of the American Psychiatric Association. Surviving are a daughter, his mother and a sister.

Joseph Goethe Graver, M. D., Cleveland; College of Physicians and Surgeons, Baltimore, 1907; aged 68; died February 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Graver practiced for several years in Akron before going to Cleveland where he was on the staff of University Hospitals. Surviving are his widow, two brothers and a sister.

Clarence Edwin Harco, M. D., Newcomerstown; Hahnemann Medical College, Philadelphia, 1944; aged 29; died February 10; former member of the Ohio State Medical Association and the American Medical Association in 1948. Dr. Harco was a veteran of World War II. He went to Newcomerstown last June from Lakewood.

Harry B. Harris, M. D., Dayton; University of Pennsylvania School of Medicine, 1894; aged 76; died February 16; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American Academy of Ophthalmology and Oto-laryngology; member of the American College of Surgeons. Dr. Harris practiced in Dayton since 1904. He was a member of several Masonic Orders. His widow survives.

Floyd Michael Hellwarth, M. D., Phoenix, Ariz.; Ohio Medical University, Columbus, 1906; aged 68; died February 15; listed in the A. M. A. Directory as a member of the Oregon State Medical Association and a Fellow of the American Medical Association. Dr. Hellwarth left Ohio to practice in Toledo, Ore., and upon his retirement moved to Arizona. His widow survives.

William Sebald Keller, M. D., Cincinnati; Miami Medical College, Cincinnati, 1904; aged 66; died March 9 in Clearwater, Fla.; member of the Ohio State Medical Association and the American Medical Association through 1948. Dr. Keller practiced medicine in Cincinnati until his retirement about 10 years ago. During World War II he served with the U. S. Public Health Service. He was on the staff of the University of Cincinnati College of Medicine. Surviving are his widow, five daughters and a sister.

Ronald Bradshaw Kieffer, M. D., Toledo; Ohio State University College of Medicine, 1937; aged 39; died March 1; member of the Ohio State Medical Association and the American Medical Association; secretary-treasurer of the Henry County Medical Society in 1940. Dr. Kieffer practiced medicine for a few years in Napoleon and in 1942 went to Toledo where he was on the staff of William Rocke Memorial Hospital. Surviving are his widow, young daughter, his parents, two brothers and three sisters.

Herman Henry Lahke, M. D., Cincinnati; Miami Medical College, Cincinnati, 1903; aged

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72; died February 26. Dr. Lahke practiced in Cincinnati for approximately 45 years. He was a member of several Masonic Orders and the Junior Order of United American Mechanics. Surviving are a sister and five brothers.

Secord H. Large, M. D., Cleveland; Medical Faculty of Trinity University, Toronto, 1893; aged 78; died March 9; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947; diplomate of the American Board of Otolaryngology; member of the American Laryngology Association, the American Laryngological, Rhinological & Otological Society, American Academy of Opthalmology & Oto-Laryngology, the American Triological Society and formerly a member of the American College of Surgeons and the American Broncho-Esophagological Association. Dr. Large practiced in his native Canada for several years before going to Cleveland just after the turn of the century. He retired from active practice in 1942. Dr. Large was nationally known and aided in organizing several national societies.

John Perry Merchant, M. D., Columbus; Ohio Medical University, Columbus, 1902; aged 70; died February 11; Dr. Merchant practiced for approximately 46 years in Columbus. He was a member of the Congregational Church. Surviving are his widow, a daughter, a son and five sisters.

Charles Amandon Palmer, M. D., Columbus; Eclectic Medical College, Cincinnati, 1920; aged 56; died February 27; Dr. Palmer practiced for a number of years in Laurelville before going to Columbus. He was a veteran of World War I, and was a member of the Catholic Church. Surviving are his widow, two sons, a daughter and a sister.

Walter Curtis Roller, M. D., Van Wert; Cincinnati College of Medicine and Surgery, 1898; aged 79; died February 15 in Dayton; former member of the Ohio State Medical Association and the American Medical Association through 1941; vice-president of the Van Wert County Medical Society in 1924. Dr. Roller practiced medicine in Willshire about 37 years after which he served as resident physician in several hospitals. He retired about 10 years ago. During World War I, he served in the Army Medical Corps. Surviving are a son, a brother and a sister.

Frank Lipton Rudy, M. D., Columbus; Medical College of Indiana, 1892; aged 83; died March 2. Dr. Rudy came to Ohio in 1912 after practicing in Minnesota and Illinois. He was a member of the Linden Council at the time the village was annexed to Columbus. Surviving are his widow, two daughters, two sons and a stepson.

Barton A. Souders, M. D., Cambridge; Starling Medical College, Columbus, 1892; aged 83; died March 3; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Guernsey County Medical Society in 1935 and 1938; and delegate to the O. S. M. A. from 1930 through 1932 and in 1939. Dr. Souders practiced medicine at Winterset for a number of years before moving to Cambridge in 1914 where he continued his practice until an injury forced his retirement about 10 years ago. He was a member of the United Presbyterian Church. Surviving are his widow, two daughters, one son and two sisters.

Elizabeth Marie Weaver, M. D., Akron; Cleveland College of Physicians and Surgeons, 1902; aged 77; died January 12; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1946. Dr. Weaver was admitted to the Summit County Medical Society in 1903 and was treasurer, 1905-1907.

Washington A. White, M. D., Cambridge; Eclectic Medical College, Cincinnati, 1880; aged 98; died February 10. Dr. White practiced his profession in Salesville for approximately 60 years. He retired and moved his residence to Cambridge about 11 years ago. He was a former member of the Guernsey County School Board and was a member of several Masonic Orders. Surviving are two daughters and two sons.

COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, April 19-22.

American Medical Association, Annual Session, Atlantic City, June 6-10.

American College of Allergists, Annual Meeting, Chicago, April 14-17.

American Goiter Association, Madison, Wis., May 26-28, 1949.

American Roentgen Ray Society, Cincinnati, week of Oct. 3.

International and Fourth American Congress on Obstetrics and Gynecology, New York City, May 14-19.

Mahoning County Medical Society, 21st Annual Postgraduate Assembly, Youngstown, April 13.

Northern Tri-State Post-Graduate Medical Association, Fort Wayne, Ind., April 12.

It is estimated that just prior to World War I, about 40 per cent of confinements were attended by midwives. By 1935 the proportion had dropped to 10.7 per cent, and in 1947, the latest year for which figures are published, reached an all-time low of 4.8 per cent.

Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLINTON

Dr. H. B. Davidson of Columbus spoke on "Congestive Heart Disease" at the March 1 meeting of the Clinton County Medical Society in Wilmington.

Second District

(COUNCILOR: H. C. MESSENGER, M. D., XENIA)

CLARK

"Fractures" was the subject discussed by Dr. C. W. Hullinger, Springfield, at the Feb. meeting of the Clark County Medical Society. Dr. Hullinger illustrated his talk with color motion pictures released by the American College of Surgeons.

DARKE

Dr. Roger M. Gove of Piqua spoke on "Psychiatric Problems" at the Feb. 15 meeting of the Darke County Medical Society, in Greenville. Dr. W. B. Taggart of Dayton spoke on "Present Status of Immunization in Children" at the March 15 meeting of the Society.

MIAMI

An illustrated talk on "Polypoid Disease of the Colon and Rectum," was given by Dr. Robert E. Pumphrey of Dayton at the February meeting of the Miami County Medical Society.

MONTGOMERY

Dr. George Crile, Jr., of Cleveland spoke on the subject, "Hyperthyroidism" at the March 4 meeting of the Montgomery County Medical Society at the Engineers Club in Dayton.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

HANCOCK

Members of the Hancock County Medical Society heard a talk on treatment of fractures by Dr. James M. McBride of Lima at the Feb. 10 meeting in Findlay. Mr. J. A. Hartley of Ohio Medical Indemnity, Inc., explained provisions of the prepayment surgical plan, and Mr. A. Stratton explained the Blue Cross plan.

LOGAN

Mr. George H. Saville, Columbus, public relations director for the Ohio State Medical Association, addressed the Logan County Medical Society at Bellefontaine on March 1. He discussed legislation in the field of medicine and public health, and the A. M. A.'s educational program.

MARION

Dr. Earle B. Kay, Cleveland, spoke on diagnosis and treatment of chronic chest diseases at the Feb. 8 meeting of the Marion County Academy of Medicine. Mr. Cecil W. Gabler, principal of the Vernon Junior High School, discussed medical problems in connection with injuries of boys on school teams, after which the Society issued a statement of policy on the treatment of such injuries.

WYANDOT

Officers of the Wyandot County Medical Society are the following: Dr. A. M. Mogg, Upper Sandusky, president; Dr. F. M. Smith, Sycamore, vice-pres.; Dr. F. M. Kenan, Upper Sandusky, secy.-



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treas.; Dr. C. B. Schoolfield, Upper Sandusky, delegate; and Dr. Smith, alternate.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

DEFIANCE

A discussion of the diphtheria immunization problem was held at the January meeting of the Defiance County Medical Society. The society adopted the following program: That the physicians encourage immunization of pre-school and school children; that a uniform fee of two dollars be charged for the series of "shots"; and that in event a child is not immunized by his physician that the health department undertake a program of immunization.

Dr. Carll S. Mundy of Toledo, Councilor, commended the Society on its attempt to solve one of the community problems. He reviewed dangers of a Federal medical program and stated further that the medical problem of any community can be solved better on a local basis. He recommended that the Society actively back the drive for a better financial public health program in the State.

A Ten-Point County Medical Society Program was adopted at a special meeting of the Defiance County Medical Society on Feb. 23. The program is as follows: (1) Encourage voluntary hospital insurance; (2) Encourage medical and surgical insurance; (3) Encourage expansion of facilities, i.e., Hicksville and Defiance hospitals; (4) Encourage adequate public health facilities to include pasteurized milk, sewage treatment and animal diseases spread to humans; (5) Encourage a mental hygiene program; (6) Encourage health education; (7) Encourage adequate care for the aged; (8) Develop cancer control program; (9) Develop safety control program—farm and highway, and (10) Encourage studies of the soil and its relationship to nutrition.

It was decided that a radio program would be undertaken as soon as materials could be gathered and arrangements made.

At the regular meeting of the Society, Dr. Francis M. Lenhart, secretary-treasurer, gave a report of the A. M. A. Rural Health Conference held in Chicago.

LUCAS

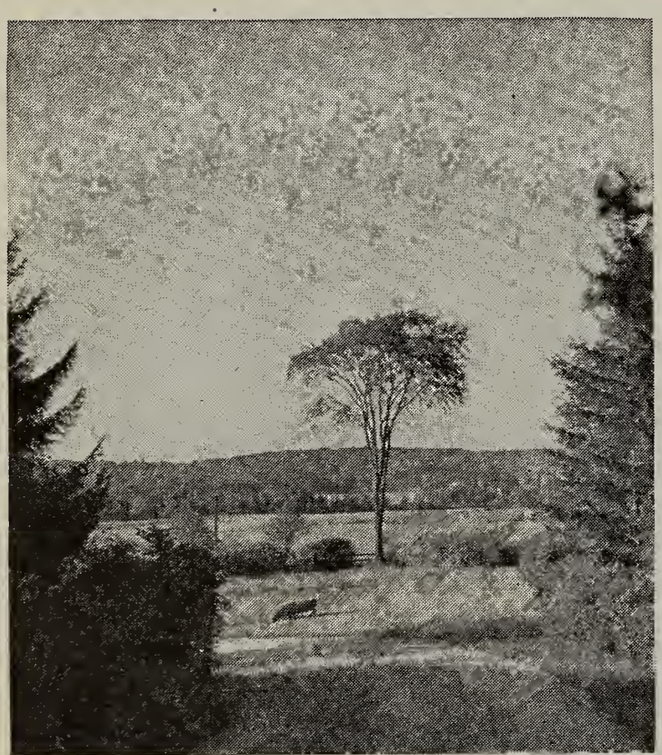
The following resolution was passed at a recent meeting of the Academy of Medicine of Toledo and Lucas County:

"Whereas, the people of the United States under a system of free enterprise now have the benefit of the highest standard of medical treatment and research in the world; and

"Whereas, the benefits of American Medicine are available to the people of this country through voluntary prepayment insurance which is accepted by the people as the American way; and

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"Whereas, the American Medical Association has presented a comprehensive democratic health program wherein government control of medical services will not be necessary and will not cause the deterioration of medical standards and medical care to the detriment of the health of our people, now therefore,

"Be it resolved, that the Academy of Medicine of Toledo and Lucas County, a society of 450 physicians, does hereby go on record against any form of compulsory health insurance or any system of political medicine designed for national bureaucratic control; and

"That a copy of this resolution be forwarded to the President of the United States, to each Senator and Representative of the State of Ohio and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent enactment of such legislation."

PAULDING

Dr. G. L. Doster, Paulding, and Dr. K. C. Evans, Payne, were re-elected president and secretary-treasurer, respectively, of the Paulding County Medical Society for 1949. Other officers are: Dr. R. J. Dillery, Paulding, pres.-elect; Dr. R. H. Mouser, Paulding, delegate; and Dr. Evans, alternate. A substantial contribution was made by the Society toward a hospital improvement fund which is now being promoted by the Paulding Chamber of Commerce.

WOOD

The Wood County Medical Society held its regular dinner meeting at the Everglades Restaurant, south of Perrysburg, on Feb. 17. Dr. Paul F. Orr presided. A short time was devoted to a discussion of recently introduced legislation and to the proposed Cerebral Palsy Clinic to be set up at the Bowling Green State University in the early autumn. The paper of the evening was given by Dr. Wendell W. Green, of Toledo, on "Diagnosis and Office Treatment of Common Ano-Rectal Disorders." Of particular interest was the discussion of the use of X-rays in diagnosis and the anatomy of the area as related to the symptomology and pathology of rectal trouble. The projected color photographs aided greatly in elucidating the subject. Dr. Green was very generous in replying to the many questions asked by the members.

A rising vote of thanks was tendered him.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

A dinner dance was given by the Ashtabula County Medical Society on Feb. 21 at the Ashtabula Hotel.

LAKE

Members of the Lake County Medical Society heard the following reports at a clinical session held on Feb. 25 at the Lake County Memorial Hospital: Dr. Gerald O. Hedlund, Painesville, spoke on a new treatment for hearing disorders; Dr. Howard Stephens, Mentor, gave a report on "Incomplete Obstruction of the Duodenum"; and Dr. Ben Fisher, Fairport Harbor, discussed, "Histoplasmosis."

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

PORTAGE

Guest speaker at the February meeting of the Portage County Medical Society was Dr. James G. Kramer, Akron, who spoke on "Diseases of the Newborn." A scientific presentation on "Problems Presented by the Treatment of Common Fractures" was made by Dr. W. H. McGaw, Cleveland, at the March 3 meeting.

SUMMIT

Representatives of the Summit County Medical Society early in March met with Akron city council committeemen to discuss the subject of hospital facilities for contagious diseases. Dr. Louis G. Herrmann, University of Cincinnati College of Medicine, spoke at the March 1 meeting of the Summit County Medical Society on the subject, "Peripheral Vascular Diseases."

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Dr. John Rankin of Wheeling, W. Va., spoke on "Low Back Pain" at the Feb. 17 meeting of the Belmont County Medical Society at the Bellaire City Hospital. Representatives of the Belmont County Cancer Society outlined accomplishments in the cancer program. A technicolor movie entitled "The Fighting Lady" was shown at the March 17 meeting of the Society with discussion by Dr. Richard I. Buttia of Bridgeport.

The following resolution was adopted by the Belmont County Medical Society at a recent meeting:

Whereas: American Medicine under the administration and control of American doctors has developed the most effective and widely distributed medical care that has ever been provided, for any comparable number of people anywhere at any time.

And in the last generation 20 years of life have been added to the average expectancy of individuals at birth. Disasterous epidemics have been virtually eliminated; we have stronger, better fed children; there has been a sharp reduction in the death toll from many diseases that were formerly high on mortality list; and we have a vast storehouse of knowledge about the prevention and treatment of diseases. This

is the record of free men in the field of medicine.

And Whereas: Under the American system, free American doctors, with fearless minds, will continue to show the greatest possible amount of progress in the science of medicine and the art of medical practice and thereby be able to provide a higher and higher quality of medical care which will be continuously more widely distributed.

And Whereas: Great pressure is being exerted on Congress to pass legislation that would place under government control the health and medical care of the people of the United States.

And Whereas: Such action would impair or destroy the personal interest, initiative and private research on the part of every doctor and put the medical profession under the control of bureaucracy.

Therefore: Be it resolved that the Belmont County Medical Society is unanimously opposed to the enactment of any legislation which in any way will remove the administration and/or the control of American medicine from the American doctors and thereby stop the progress of American medicine and lead to its inevitable deterioration, all to the detriment of the average citizen of these United States.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

ATHENS

At the Feb. 8 meeting of the Athens County Medical Society, Dr. Hugh St. John presented a paper on "Endocrinology." Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, addressed the group on the subject of activities of the Association. Mr. Hart F. Page, secretary to the Association's Committee on Rural Health, discussed the recent rural health conference.

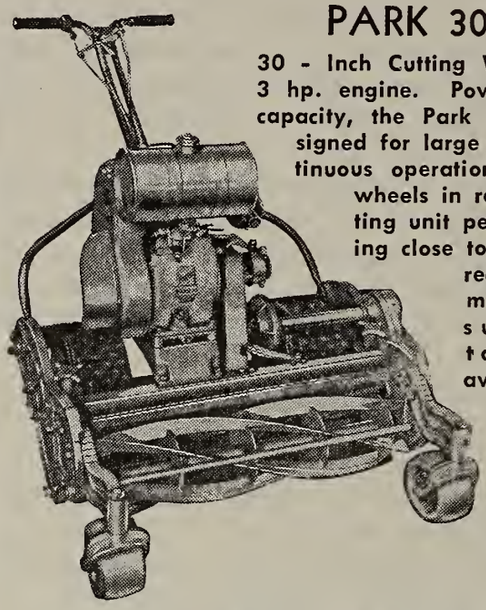
GUERNSEY

Mr. Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association, spoke informally regarding the activities of the State Association and discussed the 12-point program of the A. M. A. at the March 3 meeting of the Guernsey County Medical Society. It was announced that most of the heavy equipment for the cancer clinic had been received and that plans are to hold the first public clinic in the near future.

MUSKINGUM

"Intervertebral Discs," a discussion illustrated with movies was presented by Dr. Robert E. Slemmer of Columbus at the March 2 meeting of the Muskingum Academy of Medicine in Zanesville. The February meeting of the Academy was held in the University Club rooms, Zanesville,

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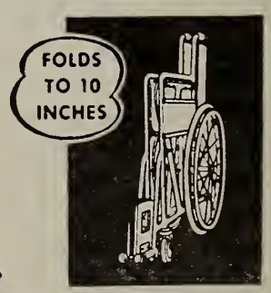
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with Dr. Maurice G. Buckles of Columbus as guest speaker. His subject was "Surgery of the Lungs."

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

GALLIA

The Gallia County Medical Society, with the Ohio Department of Health and the Gallia County Unit of the American Cancer Society held a two-day symposium on cancer at Gallipolis on Jan. 13 and 14. The symposium was attended by members of the Society, visiting physicians, public health nurses and staff nurses from the Holzer Hospital.

LAWRENCE

Needs and facilities at the Lawrence County General Hospital were discussed at the Feb. 22 meeting of the Lawrence County Medical Society in Ironton. Dr. Thomas J. Holbrook, Huntington, W. Va., spoke on the handling and care of head injuries.

SCIOTO

Dr. Norman O. Rothermich, Ohio State University College of Medicine, spoke on "Some New Concepts in the Management and Treatment of Diabetes," at the Feb. 14 meeting of the Hempstead Academy of Medicine in Portsmouth.

The Hempstead Academy of Medicine sponsored establishment of a bureau to provide emergency equipment such as wheel chairs, crutches or oxygen masks. At the March 14 meeting of the Academy, Dr. Walter C. Swann, Huntington, W. Va., spoke on "Cardiac Diseases in Relation to General Practice and the Surgical Risk."

VINTON

Officers of the Vinton County Medical Society for 1949 are: Dr. Richard E. Bullock, McArthur, president, and Dr. H. D. Chamberlain, McArthur, secy.-treas.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FRANKLIN

Speaker at the March 7 meeting of the Columbus Academy of Medicine was Dr. Irvine H. Page of Cleveland whose subject was "Recent Advances in the Etiology and Treatment of Hypertension."

Dr. Ralph A. Reis, Northwestern University Medical School, spoke on "The Present Status of Gynecologic Endocrine Therapy," at the March 21 meeting.

KNOX

Officers of the Knox County Medical Society are the following: Dr. John L. Baube, Mt. Vernon, president; Dr. Robert H. Hoecker, Mt. Vernon, vice-pres.; Dr. J. W. Allman, Centerburg, secy.-treas.; Dr. Raymond S. Lord, Fredericktown,

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delegate; and Dr. Henry T. Lapp, Utica, alternate.

MORROW

Dr. Lowell W. Murphy, Cardington, is the president of the Morrow County Medical Society for 1949. Other officers are Dr. William S. Deffinger, Marengo, vice-pres.; Dr. Francis W. Kubbs, Mt. Gilead, secy.-treas.; Dr. Joseph P. Ingmire, Mt. Gilead, delegate; and Dr. Charles S. Jackson, Mt. Gilead, alternate.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

"Treatment of Psychiatric Disorders by the General Practitioner" was the subject discussed by Dr. Joseph L. Fetterman, Cleveland, at the March 8 meeting of the Lorain County Medical Society.

The programs at other recent meeting of the Society included: An address by Dr. Rufus P. McCormick, Cleveland, on "Radio Isotopes," at the Feb. 8 meeting; and a talk on the "Management of Thyroid Disease," by Dr. Robert Dinsmore, Cleveland, at the Jan. 11 meeting.

RICHLAND

Dr. Maurice A. Schnitker of Toledo spoke on "Newer Aspects of the Physiology of the Kidney," at the January meeting of the Richland County Medical Society. A joint meeting of the Richland County Medical Society and the staff of the Mansfield General Hospital was held at the hospital on Feb. 24. Speaker for the occasion was Dr. John W. DeVore, technical director of the Regional Blood Center of the American Red Cross, Columbus, who discussed various phases of the operation of the blood bank.

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

Haddon Hall will be the headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 6 to 10, 1949. Requests for reservations should be sent at once to Dr. Robert A. Bradley, chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City.

ALLEN

Mrs. R. L. Tecklenberg was elected president of the auxiliary to the Academy of Medicine of Lima and Allen County at the meeting held on Feb. 22. A round-table discussion on industrial health, child welfare and old age aid was conducted by Mrs. H. C. Weisenbarger who read a paper on industrial health prepared by Dr. Hugh Savage. The agencies were represented by Mrs. Earl Ransbottom, society for aid to

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aged; Miss Grace Saltzgaber, executive director of the child and family welfare society; Mrs. Margaret Myers, society for aid to dependent children; and Miss Mae Peiffer, secretary of the child welfare board. Thirty members attended.

CLARK

On February 20, the *Springfield News-Sun* carried a page on "Medical Auxiliary Focuses Efforts on Nurse Recruitment." Five pictures including 22 women were shown. The group in each picture is helping to launch this program in various ways.

The initial step in the auxiliary's recruitment program was the mailing of letters to all senior, junior and sophomore girls in high schools throughout the city and county, enclosing pamphlets relating to nursing. A follow-up file was established by the committee. Posters are being placed. Talks at various county high schools are being arranged by the Springfield City Hospital School of Nursing. The Superintendent of nurses is giving the talks. She is provided transportation by members of the medical auxiliary. As part of the Career Day Program planned for late April for Springfield High School students, the medical auxiliary committee will conduct two sessions during which the film, "R. N. Serving All Mankind," will be shown. Discussion periods also will be held. The committee also will be in charge of the social hour at Springfield City Hospital's open house on Career Day.

Mrs. George Winwood, Jr., reviewed the book "Nursing for the Future" for members of the Woman's Auxiliary to the Clark County Medical Society and graduate nurses who were their guests at the Feb. 21 meeting in the Nurses' Residence of Springfield City Hospital. Mrs. E. Paul Greenawalt, chairman of the nurse recruitment and fellowship committee, introduced Mrs. Winwood, whose review was part of the committee's program on nurse education. Mrs. Frank Anzinger, Jr., president, conducted the business meeting.

CUYAHOGA

In the interest of maintaining an informed membership on an issue pertinent to their husbands' profession, the Woman's Auxiliary to the Academy of Medicine of Cleveland presented Philip W. Porter, assistant Sunday editor and columnist for the *Plain Dealer* in a talk on "The Dangers of Socialized Medicine." More than 130 attended this mid-winter luncheon meeting held on Feb. 17 in the Cleveland Skating Club. Mr. Porter, who has observed the system in England and Germany, has firsthand knowledge of how it doesn't work.

ERIE

The Woman's Auxiliary to the Erie County Medical Society met for luncheon at the Busi-

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ness Women's Club. The business meeting was conducted by Mrs. E. J. Meckstroth in the absence of the president, Mrs. W. T. Fenker. The program featured a resumé of Dr. Willard R. Cooke's pamphlet on "Differential Psychology of the American Woman" by Mrs. Dean Sheldon.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met at the home of Mrs. C. W. Brown, Lancaster, Feb. 14. Mrs. W. D. Nusbaum, vice-president, had charge of the business session. A humorous skit, "The Pitfalls of Socialized Medicine," written and directed by Mrs. G. S. Rodabaugh, was presented. Taking part were Mrs. Fred Spangler, Mrs. A. B. Van Gundy and Mrs. J. A. Geer.

FRANKLIN

The Auxiliary to the Columbus Academy of Medicine held its February meeting in the Little Theater at the Art Gallery. Dr. Samuel Renshaw, professor in the Department of Psychology at Ohio State University, spoke on "How We Learn To See Better." Mrs. Wayne Brehm, president, conducted the business meeting.

JEFFERSON

More than 80 student nurses attended the party given by the Woman's Auxiliary to the Jefferson County Medical Society in the Nurses' Home. At a business meeting preceding the party Mrs. A. E. Winston was named delegate to the State Convention to be held in Columbus in April.

Members of this auxiliary are busy promoting an essay contest which is being conducted in the junior and senior high schools in the county.

An open discussion on socialized medicine followed the regular meeting of this group on March 2. The president, Mrs. Carl Goehring, conducted the forum. Mrs. Howard Milnor gave a report on "Socialized Medicine—the Opening Wedge for Socialism." "Should the Right To Choose Our Own Doctor Be Taken Away From Us" was the topic discussed by Mrs. J. W. Metcalf of Toronto. A round-table discussion followed.

Plans were completed at this meeting for the lecture of Dr. R. J. Foster of New Philadelphia, Seventh District Councilor, on March 21. Dr. Foster discussed "Socialized Medicine."

KNOX

Mrs. George Imhoff was hostess to the Woman's Auxiliary to the Knox County Medical Society in January. During the business session conducted by Mrs. Robert L. Eastman, the auxiliary voted a contribution to the March of Dimes and named Mrs. Eastman and Mrs. John L. Baube delegates to the State convention in Columbus in April.

The February meeting of this group was held



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GYNECOLOGY—Intensive Course, two weeks, starting April 18, June 20. Vaginal Approach to Pelvic Surgery, one week, starting April 4, May 16, June 13.

OBSTETRICS—Intensive Course, two weeks, starting April 4, May 16.

MEDICINE—Intensive Course, two weeks, starting June 13. Electrocardiography & Heart Disease, two weeks, starting July 18. Gastroenterology, two weeks, starting June 27. Personal Course in Gastroscopy, two weeks, starting May 16, June 13.

PEDIATRICS—Intensive Course, two weeks, starting April 4. Diagnosis & Treatment of Congenital Malformations of Heart, two weeks, starting June 13.

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at the home of Mrs. John C. Woodland. During the program hour Mrs. Workman spoke on "Antiques and My Mistakes; or Do's and Don't's in 'Antiquing'"; and Mrs. O. W. Rapp gave a short talk on the school health program. Mrs. E. V. Ackerman, school health coordinator, told of her work and gave demonstrations of the Snellen chart for testing eyes and the audiometer in testing hearing.

LAKE

Mrs. Farrell T. Gallagher of Cleveland, State chairman of public relations, addressed the Auxiliary to the Lake County Medical Society at the luncheon meeting in February. Mrs. G. O. Hedlund, president, conducted the meeting which 21 members from the Lake County and Ashtabula County auxiliaries attended. Mrs. C. C. Campbell, president of Ashtabula auxiliary, told of their program.

At the March meeting of the Auxiliary, highlights of the meeting of the Auxiliary to the Academy of Medicine of Cleveland were given by Mrs. Park and Mrs. Hedlund who attended. Mrs. Jerome Wertheimer told of the progress being made on the hospital library for doctors.

LICKING

Six new members were received by the Auxiliary to the Licking County Medical Society at the dinner meeting held in Granville Inn. Received into membership were Mrs. K. P. Scott, Mrs. W. J. Kennedy, Mrs. W. N. Koontz, Mrs. L. J. Tilton, Mrs. V. R. Turner and Mrs. James Johnson.

Members of the board of directors of the Licking County Medical Society including Dr. W. E. Shrontz, Dr. John McClure and Dr. Lawrence H. Miller of Granville addressed the meeting, counselling on public relations, welfare and legislation. Mrs. J. Fleek Miller also talked on public relations.

LUCAS

At the regular monthly meeting, Feb. 15, of the Auxiliary to the Academy of Medicine of Toledo and Lucas County, 80 members were present for luncheon at the Woman's Building. A talk on "Alcoholics Anonymous" was heard by the group.

Toledo's first effort to raise funds to fight heart disease was aided by members of this auxiliary recently. The auxiliary helped to distribute one hundred plastic hearts which were placed in stores and offices throughout the city for collection of contributions.

On March 1 in St. Mark's Episcopal Church, a general meeting and "Friendship Tea" was held by this auxiliary. Dr. Wilbur W. White, president of the University of Toledo, was the guest speaker. His subject was "Education—Its Future and Its Needs." Mrs. E. Benjamin Gillette, Mrs. Wendell W. Green, Mrs. F. W.

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Clement and Mrs. William Mundy presided at the tea tables.

MONTGOMERY

On Feb. 8 the Woman's Auxiliary to the Montgomery County Medical Society held a luncheon meeting at the Engineers Club with 83 members and two guests present. It was reported at this meeting that $50 is being presented to the student nurse group of each hospital, the Good Samaritan Hospital, St. Elizabeth Hospital and Miami Valley Hospital.

The guest speaker for the afternoon was Mrs. Albaugh, second vice-president of the Tenth District Ohio State Nurses Association. Mrs. Albaugh is active in recruiting prospective nurses.

OTTAWA

A prolonged discussion of medical legislation now pending, marked the February meeting of the Auxiliary to the Ottawa County Medical Society at the Lakeside home of Dr. and Mrs. Jack Witker. Eight members were present. Following the meeting, doctors joined their wives and a social hour with refreshments was enjoyed. Achievements of the auxiliary were scheduled to be presented in a radio broadcast from WLEC in March on the Lake Shore Dairy Program.

PICKAWAY

The meeting of the Womans Auxiliary to the Pickaway Medical Society was held Feb. 28 in Pickaway Country Club. Following the luncheon, Miss Grace Collett, psychologist of Harding Sanitarium, spoke on the subject, "The Value of Psychological Tests in Diagnosis." Slides of various tests were shown with explanation of their significance.

RICHLAND

Fifty-one members and guests were present for the March meeting of the Woman's Auxiliary to the Richland County Medical Society at the Women's Club with Mrs. H. Stiles and Mrs. H. Campbell as hostesses. Mr. R. C. Jenkins of Akron discussed the Blue Cross plan.

ROSS

Establishment of a student nurses' loan fund highlighted the March meeting of the Woman's Auxiliary to the Ross County Academy of Medicine, following dinner at Allyn's Dining Room. Sixteen members were present.

Mrs. E. H. Artman, president, conducted the business session during which the group made plans to meet March 11 at the home of Mrs. Loy E. Hoyt to sew for Chillicothe Hospital.

Detailed reports were presented by the following committee chairmen: Mrs. F. W. Nusbaum, radio; Mrs. Walter E. Kramer, ways and means; Mrs. Ward Smith, *Hygeia;* Mrs. Harold Crumley, public relations; and Mrs. Charles Hoyt, program.

SCIOTO

Turning the tables Feb. 10, local doctors' wives—members of the Auxiliary to the Hempstead Academy of Medicine—entertained the husbands at a banquet in the Four Keys restaurant. Each December the local physicians honor their wives with a holiday banquet and Thursday evening's party was the first "return" sponsored by the wives.

Dinner covers were laid for about 100. For the program, the Rev. Laurence H. Hall, rector of All Saints Episcopal Church, gave a humorous

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talk and presented some of his magic tricks. The new oxygen mask purchased by the auxiliary for the lend-aid bureau was displayed.

On March 7 this group met in the Ohio Power Company auditorium for a food demonstration and business meeting. Officers for the coming year were elected. Mrs. W. A. Ray will succeed Mrs. George E. Obrist as president.

TUSCARAWAS

The regular meeting of the Auxiliary to the Tuscarawas County Medical Society was held at the home of Mrs. H. F. Van Epp, Dover, Feb. 10. Fifteen members were present. Mrs. R. J. Foster, New Philadelphia, was appointed delegate and Mrs. W. R. Stager, Dover, alternate to the State convention in April. Mrs. Burrell Russell, New Philadelphia, entertained the group with a summary of their recent trip west using one of the plan-of-journeys recommended in Fred Bund's book "Westward How."





CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

PHYSICIAN ANESTHETIST, full charge, metropolitan area, voluntary general hospital; please write fully. Box 43, Ohio State Medical Journal.

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FOR SALE: Complete office furniture, equipment and instruments for physician; also recently remodeled home with separate professional and residence quarters in Stow, Ohio, community of 10,000, virtually in suburban Akron. Apply L. E. Gaylord, Administrator, First National Tower, Akron, Ohio.

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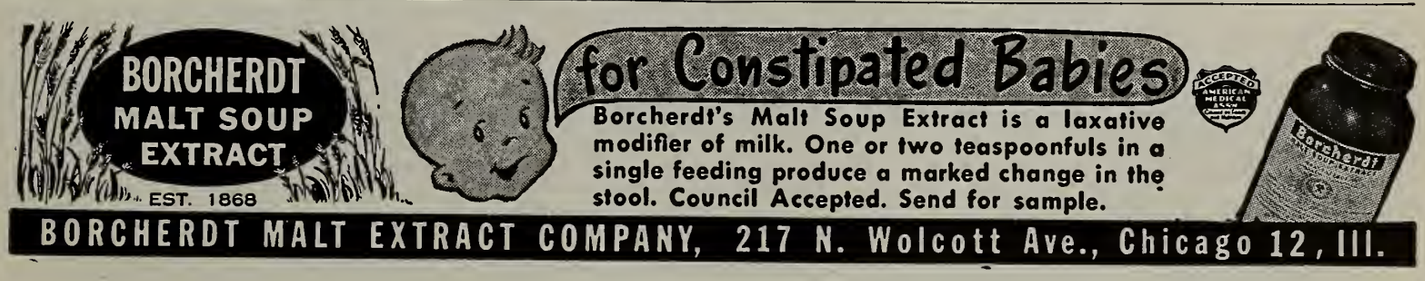
WANTED: Thoroughly competent physician for a month or longer for physical examinations. 200 Republic Bldg., Cleveland 15, Ohio.

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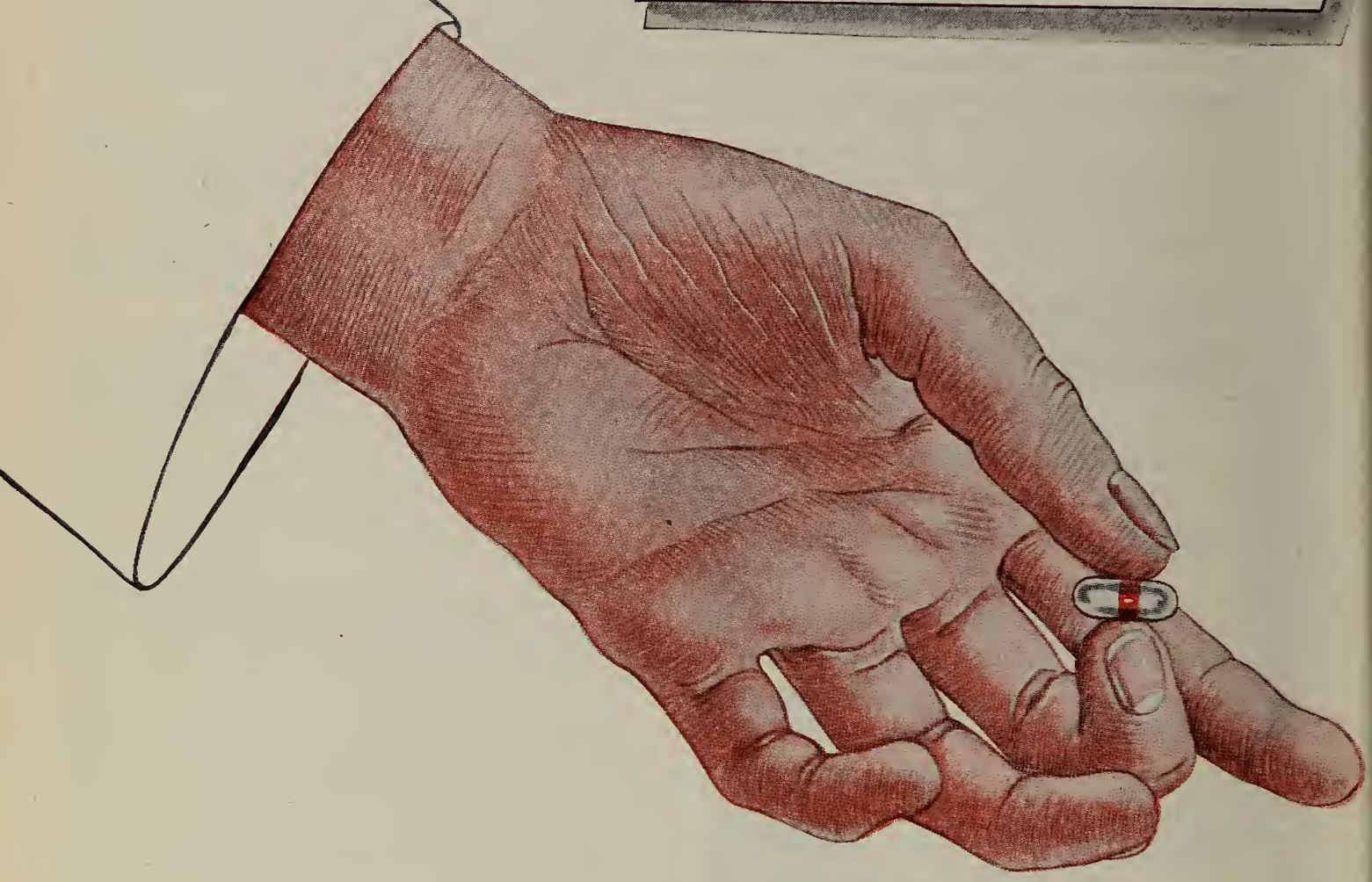
FOR SALE: Beck-Lee Electrocardiograph just returned from complete factory overhaul. Box 57, Ohio State Medical Journal.

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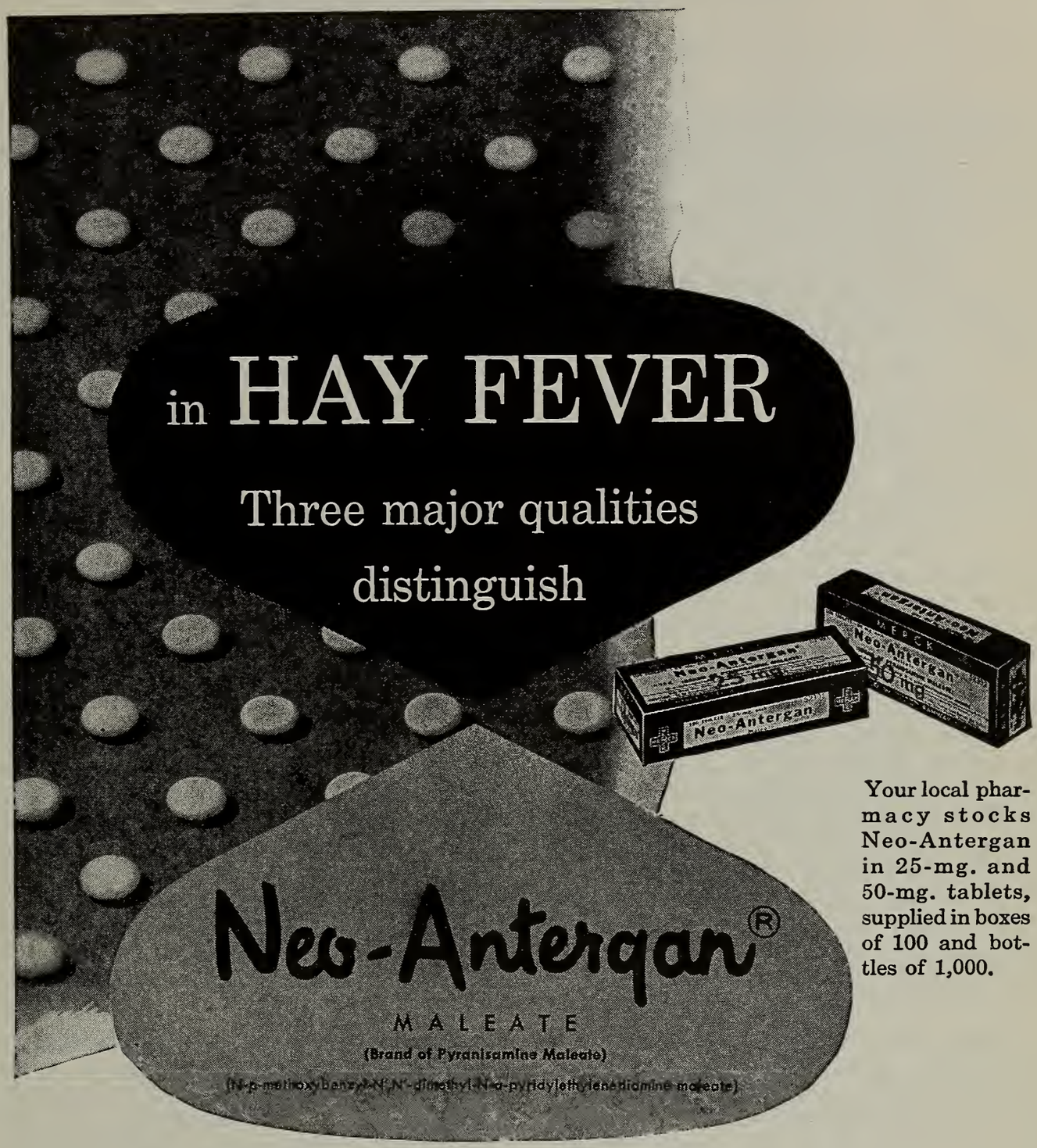
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*Magladery, J.: Therapeutic Conference, The Treatment of Epilepsy. Bull. Johns Hopkins Hosp., 82:609, (June) 1948.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Psychodynamics and the Allergic Patients, by Harold A. Abramson, M. D., F. A. C. A., ($2.50. *American College of Allergists, LaSalle Medical Building, Minneapolis 2, Minnesota)* is the first of several books projected by the American College of Allergists. It pleases your reviewer much to welcome it since some seven or eight years ago, it was his advice that such monographs be issued by the Society. This book is equally important with the score or more of other books which have appeared emphasizing the chemical factors (antigens, electrolytes, etc.) involved to a greater or lesser degree in the production of the allergic reaction and two or three that have emphasized the physical components (weather, climate, heat, cold, and light). To produce the allergic response on the part of the cell requires varying mixtures of physical, chemical, and psychological stress. All must be held equally worthy of attention on the part of the physician who would help the allergic patient.

In the meantime, we must not forget that in the allergic response of the cell, there are certain factors equally worthy of consideration. These are inheritance (already over-emphasized), nutritional status (long due for a round of attention), and the integrity of the catalytic pattern (where we need the most research).

As the first step in the coordination of organizational allergy and psychodynamics, this book should prove of great help to every allergist who will give it its proper place along with the other five essential factors to be considered.

Obstetric Analgesia and Anesthesia, by Franklin F. Snyder, M. D., ($6.50. *W. B. Saunders, Philadelphia)* pays particular attention to their effects on mother and child—Hazards inherent in their use. It is a "must book" for obstetricians, anesthetists and studys of maternal and infant mortality.

Blood Transfusion, by E. L. DeGowin, M. D., R. C. Hardin, M. D., and John B. Alsever M. D., ($9.00. *W. B. Saunders Company, Philadelphia)* is a timely book. The numerous blood banks, their management and their problems are given full consideration here as well as the clinical use of blood.

Current Therapy, 1949, edited by Howard F. Conn, M. D., ($10.00. *W. B. Saunders Company, Philadelphia)* presents the latest approved methods of treatment for the practicing physician. It is the work of the editor, twelve distinguished consultants, and 245 contributors. Among them are several of our own members: Drs. H. A. Brunsting, George Crile, Jr., John A. Gammel, Donald M. Glover, Samuel N. Maimon, and John A. Toomey.

The rising cost of book-manufacturing has created many interesting problems and attempts at their solutions. One solution has been to bind together several monographs so that they can carry themselves through the channels of trade.

Outstanding among this effort is this volume which gives precise and current information in an easily consulted form. Only methods that have been endorsed and are currently used by competent authorities are included in the text.

Doctors of Infamy, by Alexander Mitscherlich, M. D., and Fred Mielke, with introduction by Andrew C. Ivy, M. D. ($3.00. *Henry Schuman, Inc., New York City),* is the story of the Nazi Medical Crimes, uncensored, unglossed and fully documented.

Mineral Nutrition of Plants and Animals, by Frank A. Gilbert, Ph. D. ($2.75. *Oklahoma University Press, Norman, Oklahoma)* described the effects of mineral deficiences in soil upon plants, foods, animals, and Man. It is based upon a critical analysis of some 329 references by a competent research botanist. The work forms a working background to the greatly expanded agricultural research programs of the Battelle Memorial Institute of Columbus, Ohio—the world's largest private research institution, with which Dr. Gilbert has been connected since 1945.

Anatomical Pattern as the Essential Basis of Sensory Discrimination, by Professor W. E. Le-Gross Clark *(C. Bockwell Scientific Publications, Oxford, England, and Charles C. Thomas, Springfield, Illinois)* being the 49th Robert Boyle Lecture by the professor of Human Anatomy at the University of Oxford. For the anatomist, the physiologist and the physician who wants to ask if the living body is a reflect in the stream of material substance which continually passes through it; what is it, in fact, a reflection of?

Student Nurse, by Lucy Agnes Hancock ($0.25. *Pocket Books, Inc., New York City)* tells the story of two men who wanted the lovely student nurse—the Chief of Staff and a play boy.

Symptoms in Diagnosis, by Jonathan C. Meakins, M. D. ($7.50. Second Edition. *Williams & Wilkins Company, Baltimore, Maryland)* represents a valuable innovation in that few books on symptoms have been written in recent

years. As Sam Weiss says in his foreword, "Our interest in pathogenesis and laboratory aids to diagnosis has made us neglect the symptoms of disease for the last 40 years." A good diagnostician always is skillful in his interpretation of the symptoms which brought the patient to him in the first place. Experience has improved the second edition over the first.

Oral Anatomy, by Harry Sicher, M. D., ($15.00. *C. V. Mosby Company, St. Louis)* is based upon a German text upon which the author collaborated. It attempts to help correlate the facts with practice.

For the New Mother, by Mildred V. Hardcastle, R. N., ($2.00. *John C. Winston Company, Philadelphia)* is a practical manual covering month by the month until the end of the first year.

Introduction to Physiological and Pathological Chemistry, by L. Earle Arnow, M. D. ($4.00. *C. V. Mosby Company, St. Louis)* is one of the outstanding nurses text brought up to date.

The Diabetic's Handbook, by Anthony Sindoni, Jr., M. D. ($3.00. *Ronald Press, New York City)* tells the patient how to work with his doctor in treatment by diet and insulin. It is dedicated to the diabetic who realizes that he need have nothing to fear.

You—Guidebook for Health and Personal Development, by Helen Shacter, Ph. D., and W. W. Bauer, M. D., ($1.48. *Scott, Foresman & Company, Chicago).* To those of us who have not looked in on the school, a look at this book is a revelation. If you are invited to talk to a P. T. A. meeting, by all means accept, but you would do well to look through this book before you go to speak.

Clinical Aspects and Treatment of Surgical Infections, by F. L. Meleney, M. D., ($12.00. *W. B. Saunders Company, Philadelphia)* is not only a contribution to the bacteriology of infections but illustrates the significance of the reactions to those infections of the various organs and tissues of the body—a mine of information about treatment.

Mayo Clinic Diet Manual, by the Committee on Dietetics of the Mayo Clinic, ($4.00. *W. B. Saunders Company, Philadelphia)* has been developed for the guidance of physicians, fellows, dietitians, and dietetic interns and nurses of the Mayo Foundation and associated institutions. Although prepared for intramural teaching, it is a most useful book for any physician to have at hand.

A Textbook on General Physiology, by Philip H. Mitchell, Ph. D., ($7.50. Fourth Edition. *McGraw-Hill Book Co., Inc., New York City)* reviews the past ten years since the third edition and brings the text up to date.

Practice of Allergy, by Warren T. Vaughan, M. D., Revised by J. Harvey Black, M. D., ($15.00. *C. V. Mosby Company, St. Louis, Missouri)* is by far the best book of reference on the subject available today. As "Warren Vaughan's Book" it was welcomed by allergists everywhere. Dr. Black, with his judicial temperament, brilliant mind, and extensive clinical experience has revised this monumental work more successfully than any one who could have possibly been selected.

Manual of Urology, by R. M. LeComte, M. D., ($4.00. Fourth Edition. *Williams & Wilkins Company, Baltimore, Maryland)* sets forth in an easily understandable way so that the student can get at the basic facts.

Happy Days With Our Friends, by Elizabeth Montgomery and W. W. Bauer, M. D., (96 cents. *Scott, Foreman & Company, Chicago, Illinois)* is the guidebook for the primer of the health and personal development series.

The Comly and Coleman Fund, for Medical and Surgical Research of the Ohio State University, Volumes II, III and IV, *(A Collection of reprints)* presents some 65 pieces of research made possible by the generosity of Mrs. Comly.

The Business Side of Medical Practice, by Theodore Wiprud, ($3.50. Second Edition. *W. B. Saunders Company, Philadelphia)* has been extensively overhauled and revised. It contains 20 chapters on Personal Efficiency, Office Management, Case Records, How To Handle Accounts, the Charity Patient and One's Own Bills, Public Speaking, Civic Activities, Medical Leadership, How To Conduct a Meeting, as well as information about group practice and a look at the future. Every physician ought to have a copy no matter how he may practice.

Modern Medical Discoveries, by Irmengrade Eberle, ($2.50. *Thomas Y. Crowell Company, New York City)* gives a good description in popular language of Penicillin, Sulfa Drugs, Anti-Malarials, Plasma and Whole Blood, Vaccination and Vitamins.

Women and Their Money, by Maxwell Stewart (20 cents. *Public Affairs Committee Pamphlet No. 146, 22 E. 38th Street, New York City)* emphasizes that one out of every six family units in America is headed by a woman and that women do most of the buying. The phamphlet is full of just the things that an adult woman should know.

You and Others, by Helen Shacter, Ph. D., and W. W. Bauer, M. D., ($1.56. *Scott, Foresman and Company, Chicago, Illinois)* teaches the youngster through illustrations, a lesson in cooperation, in family, school, and community living in terms of health and happiness.



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Dillane, W. B. et al.: Treat. Serv. Bull. 2:47, 1947 • Downing, J. G. et al.: J. A. M. A. 133:299, 1947 • Downing, J. G.: Am. Pract. 2:357, 1948 • Downing, J. G. et al.: New England J. Med. 239:62, 1948 • Eichenlaub, F. J. et al.: M. Ann. District of Columbia 17:452, 1948 • Johnson, H. M.: Arch. Dermat. & Syph. 57:348, 1948 • Miller, J. et al.: New York State J. Med. 47:2316, 1947 • Robinson, H. M. et al.: South. M. J. 40:409, 1947.

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JONATHAN FORMAN, M. D., *Editor*

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R. GORDON MOORE,
Asst. Managing Editor

Pyarthrosis in Infancy—Report of a Case with the Review of the Literature

J. VICTOR GREENEBAUM, M. D., JOSEPH A. FREIBERG, M. D., and EUGENE L. SAENGER, M. D.

IT is a well-established clinical observation that suppurative infections of the joints, secondary to either general or local infections of the body are seen frequently in infants under two years of age. These lesions occur most often with pyogenic bacteria such as Staphylococcus and Streptococcus, but may occur during the course of any of the infectious diseases, such as pneumonia and meningococcemia.[1]

The treatment advocated for this condition prior to three years ago (1945), when penicillin first became an easily obtainable therapeutic agent, included blood transfusions, sulfonamides, general supportive measures and surgical procedures such as aspiration or incision and drainage of the joint or joints affected.[2]

There was a high mortality; and when recovery occurred, the joints involved showed serious joint changes, especially if the infecting organism was the Staphylococcus.

Keefer and his colleagues[3] in 1943 advocated injection of penicillin into the infected joints. The first reported use of this method in children was by Robertson[4] in England in April, 1944, in a 14-year old child, and by Herrel and Kennedy[5] in the United States in November, 1944, in an 8-year old child. The first detailed reports of intra-articular penicillin injections in infancy (28-day and 5-month infants), were by Tucker and Tepper[6] in 1946. Higgan, Brown, and Bodian[7] in 1947 in a series of 18 cases of osteomyelitis in infants reported six cases of suppurative arthritis in all of which cases intra-articular injections of penicillin were given. In three of these cases, the suppurative arthritis was primary, and in the remaining three cases the arthritis was secondary to adjacent osteomyelitis. Analysis of these eight cases are appended. (See Table I.) It will be noted that

Presented before the Section on Pediatrics at 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, April 1, 1948.

The Authors

● Dr. Greenebaum, Cincinnati, Ohio, is a graduate of Harvard Medical School, 1911; member, American Academy of Pediatrics; attending pediatrician, Cincinnati General Hospital; director of pediatric department, Cincinnati Jewish Hospital; and assoc. prof. of pediatrics, College of Medicine, University of Cincinnati.

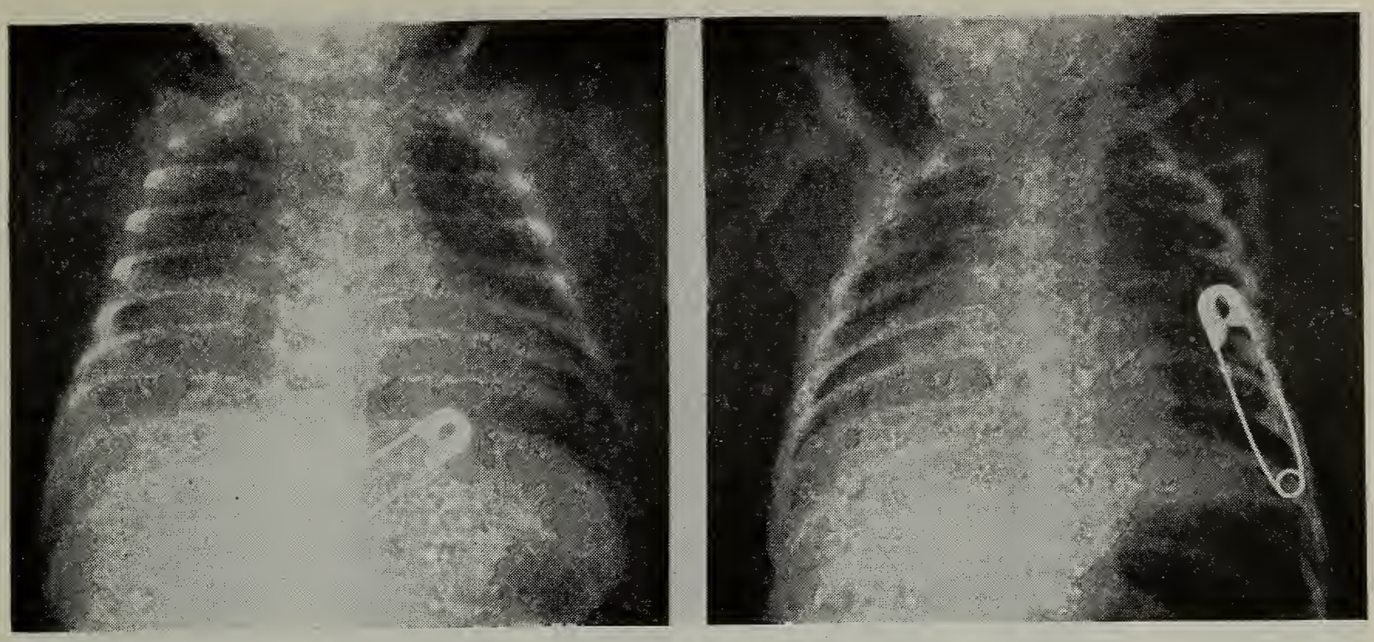
● Dr. Freiberg, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Medicine, 1923; diplomate, American Board of Orthopedic Surgery; fellow, American College of Surgeons; director orthopedic service, Cincinnati General, Children, and Jewish Hospitals; and assoc. prof. of surg., orthopedic div., and director of orthopedic dept., College of Medicine, University of Cincinnati.

● Dr. Saenger, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Medicine, 1942; diplomate, American Board of Radiology; radiologist, Mercy Hospital, Hamilton; radiotherapist, Children's Hospital, Cincinnati; and instructor, department of radiology, College of Medicine, Unversity of Cincinnati.

TABLE I

AN ANALYSIS OF THE EIGHT REPORTED CASES

Case No.	Age	Bone Lesions	Complications	Time Ill Days	Bacteriology		Surgical Treatment	Penicillin				Functional Result	Radiology
								Systemic		Local			
					Blood Cult.	Local		Time in Days	Total Dose (Units)	Time in Days	Total Dose (Units)		
SERIES OF HIGGINS, BROWNE, AND BODIAN													
5	7 wks.	Head of L. Humerus	Arthritis L. Shoulder	28	Neg.	Haem. Strep. Group A	Aspiration of Joint 8 Times	14	168,000	10	24,000	Perfect	Erosion Head of Humerus. Now Delay of Epiphys. Development Followed 13 Mos.
15	11 mos.	Neck L. Femur	Supp. Arthritis L. Hip Septicaemia	5	Haem. Strep. Group A	Haem. Strep. Group A	Immobilization Aspiration 3 Times	14	420,000	6	15,000	Ankylosis L. Hip	L. Epiphysis Not Visible. Bone Necrosis Neck of Femur. Now L. Hip Joint Ankylosed Followed 17 Months.
31	5 wks.	L. Humerus Upp. End (Head) L. Femur (Head)	Supp. Arthritis L. Hip & L. Shoulder. Subluxation (?congenital) of Hip	21	Neg.	Staph. Albus Coag. Neg.	Abduction & Extension of Legs. L. Arm Splinted Aspirations 5 Times	21	250,000	6	12,000	Shoulder Perfect Good Hip Movement L. Leg Shortened	Defect Upp. End L. Humerus. Subluxation of L. Hip. Now Displacement of L. Hip-Joint-as Before. No Evidence of Ossification of Head of L. Humerus of L. Femur. Bone Healthy Followed 10 Months.
32	18 days	?	Supp. Arthritis R. Shoulder Pneumonia, Septicaemia	7	Staph. Aur Coag. Pos.	Staph. Aur Coag. Pos.	Aspiration 15 Times	10	84,000	18	28,000	Perfect	Widening of Joint Space. No Bone Disease. Now Normal Epiphysis. Followed 21 Mos.
33	5 wks.	?	Supp. Arthritis R. Shoulder	1	Neg.	Staph. Aur Coag. Pos.	Immobilization Aspiration 4 Times	5	45,000	7	12,000	Perfect	No Bone Lesion. Followed 23 Months.
35	2 yrs.	?	Supp. Arthritis R. Knee & Both Elbows	7	None	Neg.	Immobilization Aspiration 3 Times	16	480,000	4	15,000	Perfect	No Bone Lesion. Followed 6 Mos.
SERIES OF TUCKER AND TEPPER													
1	28 days	L. Shoulder	None	17	Hem. Staph. Aureus	Hem. Staph. Aureus	Aspiration of Joint 25 Times	90	1,200,000	21	504,0000	Normal	Osteomyelitis of the Humerus & Supp. Arthritis of Shoulder Joint. Followed 13 mos. died. Autopsy of bone & joint neg.
2	5 mos.	R. Shoulder	None	20	Pneumococcus No. 7	Pneumococcus No. 7	Aspiration of Joint 7 Times	6	480,000	9	500,000	Normal	Osteomyelitis of Humerus Followed for One Year, Normal Bone



A B

Illustration 2.

A. Feb. 5, 1947: Soft Infiltrate is now present in the right lower lung field.

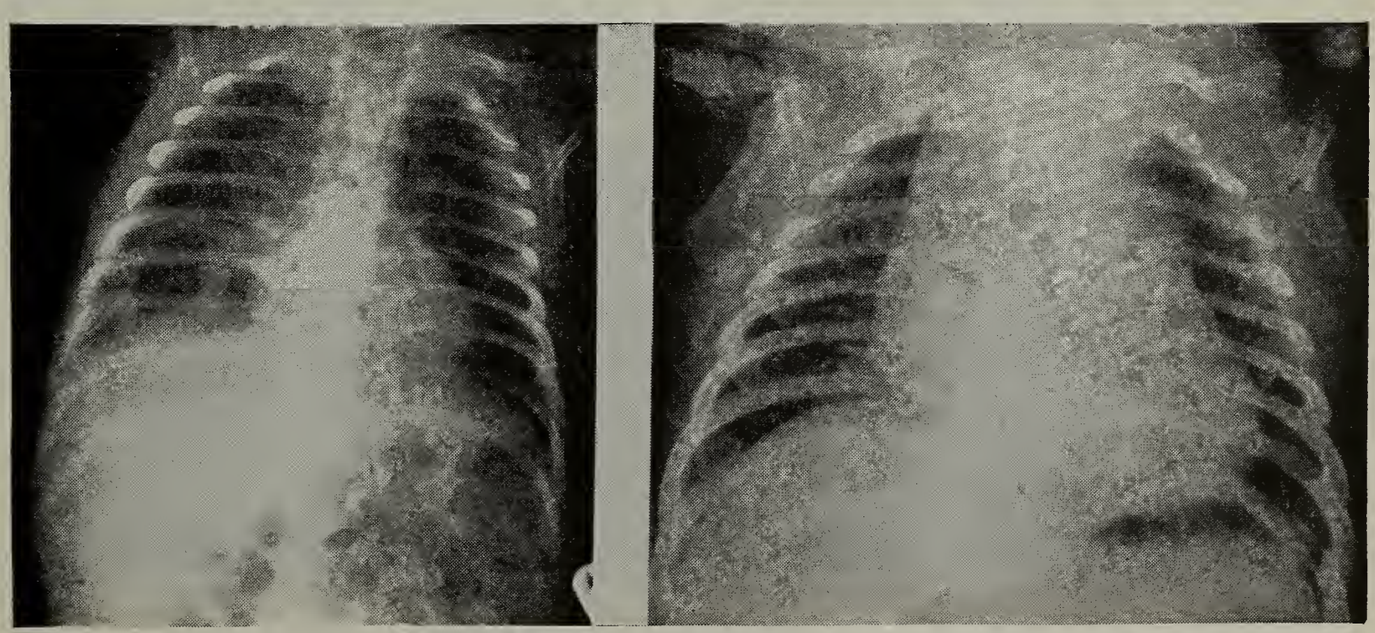
B. Feb. 6, 1947: Small areas of decreased density are now present in the infiltrate in the right lower lung field representing emphysematous bullae.

the youngest infant of the series was 18 days of age. The invading organism was Staphylococcus aureus coagulase positive. The infant had pneumonia.

CASE REPORT

Case No. 47689 at Jewish Hospital: M. G., a premature male infant, 8 months gestation, delivered of a primipara by Dr. Arthur King at the Jewish Hospital, 6:38 p. m., January 21, 1947.

The baby, a typical premature infant was first seen by one of us (J. V. G.) 9 a. m., at the age of 14 hours, January 22, 1947. It was in a Hess bed receiving oxygen. Its condition was fair. Breathing was rapid but not labored. The temperature was 104.8 degrees, not unusual in a premature baby. The length was 16 inches. The feet measured 2½ inches in length. During the examination a small amount of whitish fluid was vomited although no feeding had been given. The heart, lungs, abdomen, skin, throat, mucus membranes, eyes, ears, nose and extremities were normal. The fontanelles were level and soft; no cyanosis was present. Evaporated milk, 1/5th strength, 1 ounce every 2 hours by gavage was ordered. Oxygen was continued; .50 cc. of 5 per cent glucose was given subcutaneously. The next day on the third day of life, the temperature had fallen to normal and incidentally never became elevated again. Ten cc. of blood plasma were given. Frozen breast milk was substituted for the evaporated milk mixture and was retained well. The stools were normal. A routine portable roentgenogram was taken January 24, the fourth day of life. The roentgenogram revealed that the chest, thymus, hips and bones were negative but there was a

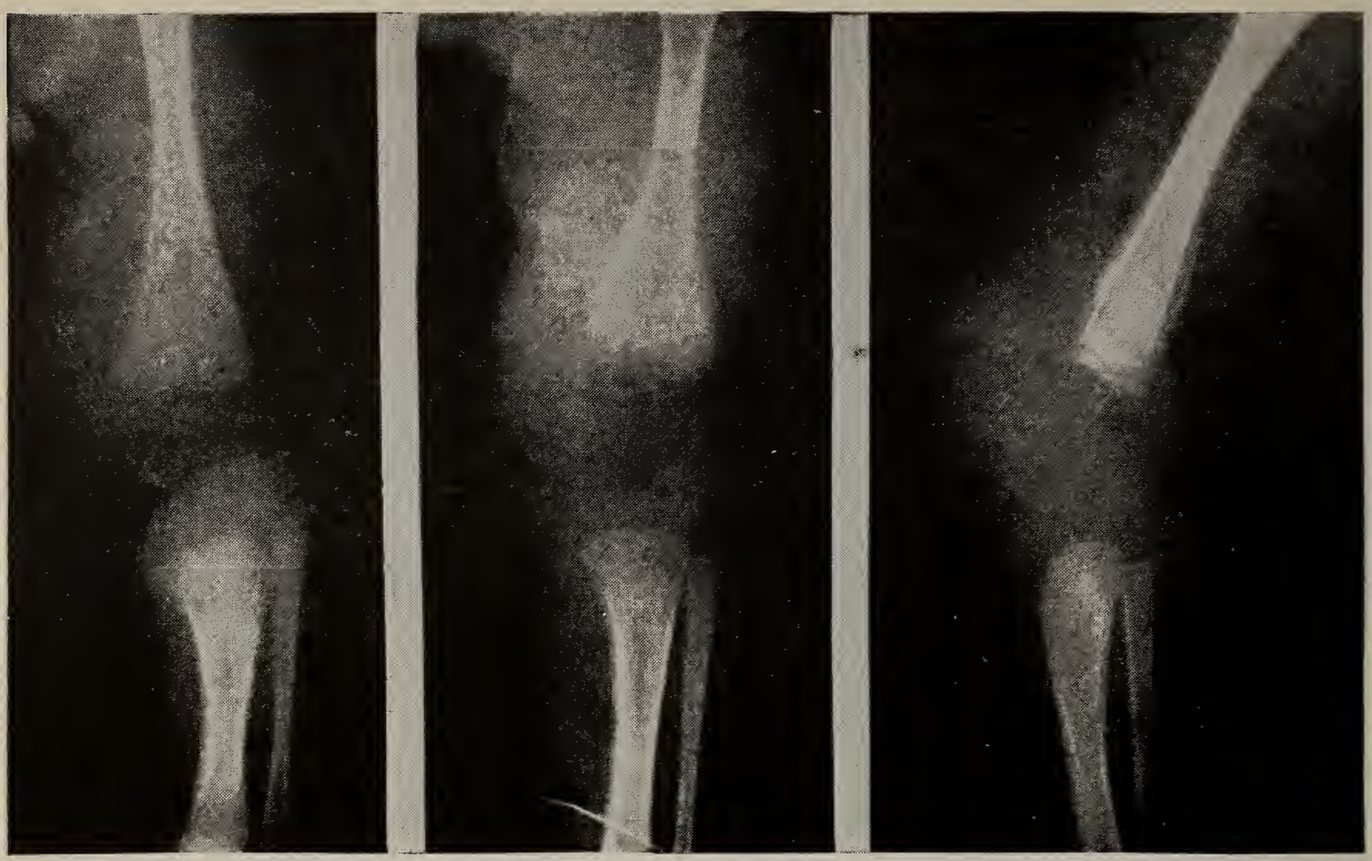


A B

Illustration 3.

A. Feb. 17, 1947: The emphysematous bullae are now much larger and the infiltrate is decreasing.

B. Feb. 28, 1947: The chest is now entirely clear.



A B C

Illustration 4.

A. Feb. 6, 1947: AP roentgenogram of the left knee shows a slight amount of cortical erosion of the medial aspect of the metaphysis of the femur (in retrospect), indicating early osteomyelitis. There is fluid in the knee joint. The distal femoral epiphysis is faintly calcified and the proximal tibial epiphysis is as yet absent.

B. and C. Feb. 17, 1947: AP and lateral roentgenograms of the left knee now show irregular destruction of the medial aspect of the metaphysis of the femur with periosteal thickening in this area. Fluid persists in the knee joint especially well shown in the lateral view.

distended stomach with only small amount of gas in the small intestines. Another roentgenogram was requested to study further the intestinal pattern. Oxygen was given only after feedings. The Mother's breast milk supply was established on the seventh day of life, and was given to the baby in the place of frozen breast milk; 20 cc. plasma was given on January 26, 1947, the sixth day of life, because the weight remained stationary and it was not possible to increase the amount of the feeding to give sufficient caloric intake.

The nurses reported that the baby cried much especially when handled but the temperature remained normal. On February 3, 1947, the thirteenth day of life, a second portable roentgenogram was taken in order to check on the intestinal pattern. It was reported that there was a normal dispersion of gas throughout the intestines and colon, but that there was an infiltrate in the right lower lung field. The extremities were normal. Cecon 10 drops and Driscol 3 drops were started. The next day, fourteenth day of life, the baby spit up a small



A B C D

Illustration 5.

A. and B. Feb. 28, 1947: The osteomyelitis is now healing but there is evidence of further destruction of the medial portion of the metaphysis of the femur. There is some increase in the periosteal thickening.

C. and D. May 26, 1947: After 3½ months the osteomyelitis is healed. There is flattening and undevelopment of the medial condyle of the femur resulting in a mild degree of genu varum.

amount of blood. Dr. K. Dodds who saw the baby in consultation found thrush on the palate and suggested merthiolate (1-5,000) swabbing of the mouth twice a day. The lungs were negative clinically. (Vitamin K was injected twice and 30 cc. of whole blood was given intramuscularly.) The blood counts were white blood count, 11,150; red blood count, 4,280,000; hemoglobin, 14.8; smear PNL 55; leucocytes, 40; monocytes, 5. Coagulation time was seven minutes, bleeding time was five minutes; both being prolonged. On the next day, February 5, 1947, the fifteenth day of life, there was evidence of consolidation in the right lower lung. (Illustration 2A.) Sodium sulfadiazine 1½ grains in 3 cc. solution was given twice a day, subcutaneously, for the next three days. The thrush had cleared from the mucus membranes, and the merthiolate swabbing was discontinued. The infant took its feedings by bottle and gained steadily. A roentgenogram taken February 6, 1947, the sixteenth day of life, showed extension of the pneumonic process and for the first time several areas of decreased density were noted in the infiltrate. (Illustration 2B.) In retrospect there is an area of cortical erosion on the medial aspect of the left femur on this date. (Illustration 4A.)

On February 8, 1947, the eighteenth day of life, the left thigh was swollen and reddened and a considerable amount of fluid was distending the left knee joint. This was confirmed by a roentgenogram. Dr. Dodds aspirated the joint and obtained a thick yellow purulent fluid. Direct smear showed leucocytes and gram positive cocci. A culture of this pus revealed hemolytic Staphylococcus aureus coagulase positive indicating it to be a virulent organism. Dr. Joseph A. Freiberg was asked to see the patient. He irrigated the joint with saline solution and instilled 40,000 units of penicillin. A posterior plaster splint was applied to the leg. Sodium sulfadiazine was discontinued. Penicillin in doses of 15,000 units intramuscularly was given every three hours and continued for twenty days. The baby was transferred to the Children's Hospital February 8, 1947, (Case No. 55549). The left knee joint was aspirated (J. A. F.) and penicillin was injected on the following dates:

February 10—7 cc. of blood tinged thick pus was obtained and 10,000 units of penicillin were instilled (10,000 units to 1 cc. of diluent).

February 12—7 cc. of seropurulent fluid obtained and 15,000 units of penicillin were instilled.

February 14—9 cc. of seropurulent fluid obtained and 20,000 units of penicillin were instilled.

February 23—7 cc. of cloudy yellow fluid with a little detritus (? pus) obtained and 15,000 units of penicillin were instilled.

March 2—2 cc. of thin cloudy fluid was obtained and no penicillin was instilled.

Cultures of the first five aspirations showed uniformly the presence of hemolytic Staphylococcus aureus coagulase positive organisms. The culture of 3/2 was negative. In all, 100,000 units of penicillin were injected into the knee joint and 2,400,000 units were given intramuscularly—total 2,500,000.

The baby continued to gain steadily and ran no fever at any time (see Chart 1). Roentgenograms of the chest February 17 showed cyst-like lesions which are characteristic of post-pneumonic emphysematous bullae. (Illustration 3A.) Films on February 28, 1948, showed the chest clear. (Illustration 3B.) Films of the femur on February 17, 1947, showed osteomyelitic changes in the distal metaphysis of the femur, a process which undoubtedly preceded the pyarthrosis. (Illustration 4B.) A roentgenogram of the femur on February 28, 1947, showed periosteal healing with further demineralization of the metaphysis. (Illustration 5A and B.) Clinically, the knee-joint was enlarged. Some crepitus was felt in the knee and the patella shifted a little from side to side in flexion and extension. The baby was discharged in excellent condition March 3, 1947, the 41st day of life. Subsequent roentgenograms following hospital discharge showed evidence of some damage to the inner half of distal femoral epiphysis with development of some genu varum deformity, though clinically the knee joint has an almost normal range of motion. (Illustration 5C and D.)

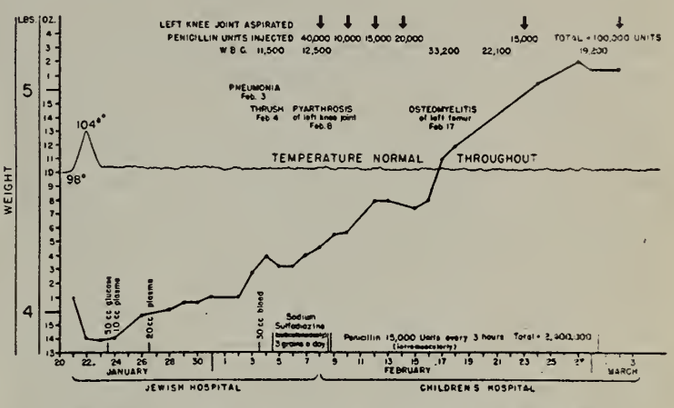


Chart 1. Chart of Clinical Course and Weight.

A chart of the blood examinations during the hospital stay is shown in Table II.

It is remarkable that the anemia in the presence of such an infection was so mild and that the leucocytosis was so moderate. The urinalysis

TABLE II

Date	HB Gms	Micro-migrog	RBC Mill	WBC	DIFFERENTIAL % N	E	B	L	M	Notes
Feb. 8	12.0		3.32	12,500	40			57	3	
Feb. 13	14.8		4.38	33,200	69	1		36	4	
Feb. 21	12.5	33.1	3.78	22,100	39			52	7	Normoblast 1
Feb. 28	10.0	28.9	3.48	19,200	37	4	1	45	13	Erythroblast 1

was negative throughout the course of the disease. No blood culture was made. Wassermann of mother was negative.

DISCUSSION

The roentgenograms of the left knee show the development of osteomyelitis of the distal end of the femur, and as noted the presence of fluid (pus) in the knee joint. The osteomyelitis resolved over a period of four weeks with failure of normal development of the medial condyle of the femur resulting in a mild genu varum deformity. The distal femoral epiphysis was but faintly calcified; this being further evidence of prematurity. During the healing of the osteomyelitis, the characteristic lag of about two weeks was noted in comparing the roentgen changes with the clinical course. This observation has been characteristic of all cases of osteomyelitis treated with penicillin.[9]

The chest roentgenograms show the typical course of the development and disappearance of postpneumonic emphysematous bullae following the initial pneumonia in this infant.[8] The pulmonary infiltrate may well have been the primary site where the Staphylococcus entered the body.

There is no apparent agreement at this time as to the dosage of penicillin to be given into the joints and into the muscles. Tucker and Tepper who suggest giving only intra-articular injections gave 500,000 to 1,101,000 units intra-articularly to their two cases, but also used intramuscular injections of penicillin and sulfadiazine. Higgins and his group in England used 4,000 to 40,000 units of penicillin intra-articularly and 45,000 to 960,000 units of penicillin intramuscularly for 5 to 21 days. All of these cases recovered completely. Our case received 100,000 units intra-articularly for 5 injections and 2,400,000 units intramuscularly for 20 days.

SUMMARY

A premature infant 18 days of age practically without general symptoms of fever, leucocytosis, and signs of sepsis, developed pyarthrosis and osteomyelitis following pneumonia. The infecting organism was Hemolytic Staphylococcus Aureus coagulase positive. Intramuscular and intra-articular injections for 20 days cleared up the pneumonia, the pyarthrosis and osteomyelitis.

CONCLUSIONS

1. Pyarthrosis and osteomyelitis may occur in infancy and even in prematurity with an insidious onset and without fever, leukocytosis, signs of sepsis, or loss of weight. Immediate aspiration of the distended joint is required for diagnosis.

2. Treatment with penicillin, both intra-articularly and intramuscularly, produced an excellent clinical response. Combined intramuscular and intra-articular penicillin is recommended for the treatment of pyarthrosis in infancy. In the reported case, the premature infant received a total dose of 2,500,000 units of which 100,000 units were injected into the joint over a twenty-day period.

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Tumors of the Peripheral Nervous System

The tumors of the peripheral nervous system form a group about which there has arisen much confusion and misunderstanding. They are not concentrated in one specialized region as is the case with the tumors of the central nervous system where they can receive the expert study of neuropathologists but are scattered at large throughout the body where they are intermingled with many other varieties of tissues and tumors and come to the attention of the general pathologist who is usually not so familiar with the behavior of neural cells. In the second place, there has raged for many years a conflict concerning the cellular composition of the nerve sheath tumors which has given rise to many confusing names and hypotheses. Again the versatility of the nerve sheath cells which permits them to form tissues such as bone, cartilage, fibrous connective tissue, striated muscle and the like provides a potent source of confusion for the unwary oncologist when he encounters manifestations of this metaplastic activity in tumors. Finally, the infrequence of the different tumors has made it difficult for any one individual personally to observe all of the different disguises in which the tumors may present themselves and thus obtain a synoptical survey of the entire group.

In order to understand these tumors it is necessary to appreciate that, like the tumors of the central nervous system, those which develop from the peripheral nervous system are largely derived from neurectoderm and not from mesoderm no matter how they may disguise themselves. There is ample evidence from many sources that neurectodermal cells can produce tissues which more commonly are derived from mesoderm.—A. P. Stout, M. D., N. Y. C., Journal of the Missouri State Medical Association, Volume 46, No. 4, April, 1949.

Myotonia Congenita (Thomsen's Disease) Report of a Case

CHARLES R. FREEBLE, JR., M. D., and JEROME M. RINI, M. D.

MYOTONIA Congenita was first described by Asmus Julius Thomsen (1815-1896), a Danish physician, in 1876, who reported the disease occurring in his own family for four generations. Myotonia congenita is described as a disease which is usually congenital and hereditary, characterized by tonic spasm and rigidity of certain muscles when an attempt is made to move them after a period of rest or when mechanically stimulated. The stiffness disappears as the muscles are used. Skeletal muscles are often over-developed, although muscular power may be diminished. Reflex contraction such as coughing or sneezing may also cause spasm. The exact pathogenicity is as yet unknown, however, there is general consent that it arises at the myoneural junction. Lindsley and Curnen[1] and later Briscoe[2] suggest that myotonia congenita is brought about by a hyper-excitability to normal amounts of acetylcholine. Other workers have suggested that there may exist an increased amount of acetylcholine or a decreased amount of cholinesterase.[3] Wolf,[4] demonstrated that administration of quinine resulted in a specific improvement of myotonia through the diminution of the reflex action, a known property of the drug. Following is a report of a case recently seen at the Central Ohio Rapid Treatment Center.

CASE REPORT

Patient, C. G., was a nineteen-year old, white, male foundry worker who was referred for the treatment of early syphilis. Four months previous to admission he developed penile lesions which disappeared in a few weeks, but were soon followed by an eruption involving the palms, soles, neck and arms. The eruption persisted until the time of admission. The patient received no anti-syphilitic therapy during the interval. Kahn, Kline and Kolmer Wassermann tests on the patient's serum were positive with a quantitative reagin titre of ten Kahn units. Spinal fluid findings were within normal limits. Routine complete blood count and urinalysis were negative, as was a routine chest X-ray. A diagnosis of secondary syphilis was established and the patient was given a standard course of intensive therapy including penicillin, arsenoxide, and heavy metal.

The patient first noticed muscular stiffness at the age of nine when an incident occurred which nearly had a fatal termination. While crossing a street it was necessary for him to move rapidly to avoid an on-coming car, and he found himself "stiffening up and unable to move." He was able, however, to fall forward so that he was not injured. From the course of the succeeding years of his life he is able to quote numerous instances, which were usually embarrassing, arising from the myotonia. Occasionally he was unable to release handshakes. While in the Army, he was often accused of malingering at the beginning of calisthenic periods and marches because he was unable to make fast movements without a prior limbering. On numerous occasions he found it necessary to make several attempts to arise from a chair. The patient also had noted that extremes in temperature and fatigue resulted in an aggravation of his symptoms.

Physical examination revealed a generalized muscular hypertrophy. On tapping various muscular groups there was a rapid contraction of the muscle followed by a slow relaxation which resulted in "grooving" of the skin over the muscles tapped. According to Wilson[6] the diagnosis of myotonia congenita is based on the triad of fine physique, myotonia, and heriditofamilial history, although the first and last members of the triad may be absent. Careful questioning of the patient concerning familial tendency for the disease was negative. The remainder of the physical examination, including a complete neurological examination was negative.

The patient was given quinine hydrochloride, 5 grains three times a day. Within seventy-two hours there was a marked subjective improvement in the symptoms. On tapping the muscles the "grooving" was scarcely discernible. During his ten-day stay in the Central Ohio Rapid Treatment Center no toxic manifestations were noted from the quinine and the patient was discharged on this routine.

Submitted June 4, 1948.

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Aureomycin in Infections of the Urinary Tract*

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AUREOMYCIN (Duomycin, Lederle)** is a new antibiotic recently demonstrated to be effective in the treatment of various bacterial and rickettsial infections[1, 2, 3, 4, 5] which are relatively resistant to penicillin, streptomycin and the sulfonamide drugs. In this paper are presented the results of clinical and bacteriologic observations in a small group of ten cases of previously resistant urinary tract infections. In the majority of these cases the infecting organism was of the E. coli group and several had a mixed infection of both E. coli and staphylococcus.

Aureomycin presents several distinct advantages in the treatment of these infections:

1. The drug is apparently non-toxic.
2. Aureomycin is given orally in the form of capsules administered in divided doses three or four times daily with minimum or no gastro-intestinal irritation.
3. Hospitalization for treatment is not a necessity since the drug can be used effectively in both home and ambulatory patients.
4. Infections resistant to other antibiotics can be controlled.
5. In bacillary urinary tract infections the rapid development of resistant strains, as previously experienced with the use of streptomycin, apparently does not occur with aureomycin.

INDICATIONS

There is very frequent incidence of resistant acute and chronic urinary tract infections on the medical, surgical, urological and obstetrical services of a hospital as well as in office practice. As a complication of chronic prostatitis, in diabetes, in postoperative surgical cases and following prostatectomy, these bladder infections present a vexing problem. The use of sulfonamide drugs is frequently attended by indifferent success and the ever present threat of renal damage. Penicillin is effective in only a small percentage of cases. Streptomycin produces a distressingly large number of patients with toxic eighth nerve symptoms besides the rapid development of resistance to the drug by bacillary infections.

Aureomycin appears effective against urinary tract infections due to E. coli where other measures have failed. If the focus of infection is associated with a chronic pyelitis, chronic prostatitis or other focal abscess, the drug cannot be expected to sterilize this focus. However, in such cases relief of bladder symptoms and the return of a "clear" urine can be achieved pending the application of more specific measures. The drug may be given for a few days before and for a week following prostatectomy to control the inevitable bladder infection. The resistant infections seen in the "cord" bladder of neurosyphilis or following combined resections of the lower colon are amenable to treatment with aureomycin. In one such case treated successfully the urine was so "milky" with pus that difficulty was experienced in catheter drainage. Culture of the urine in a dilution of one to one million grew out 400 colonies of E. coli on the agar plate. Aureomycin in a dosage of 1.5 grams daily produced a clear urine, sterile to culture, in four days. Symptomatic relief of the patient was equally dramatic. Several female patients seen in office practice with chronic and recurrent cystitis and trigonitis were successfully treated. In one of these, repeated catheterized urine cultures failed to demonstrate any infecting organism, yet symptomatic relief was obtained promptly and pus cells disappeared from the urinary sediment.

A resumé of the cases treated is included in the table.

COMMENT

The simplicity in administration of aureomycin is appealing. No gastro-intestinal complaints due to the use of the drug were encountered. One female patient developed a crural dermatitis spreading to the inner aspect of the thighs that was thought to represent a sensitization reaction. This dermatitis subsided promptly on withdrawal of the medication. Frequently a peculiar yellowish-green opalescence was noted in the voided urine and was considered to be due to pigment derived from the drug. This color effect in some

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* From the Akron Clinic and the Medical Service, Peoples Hospital, Akron, Ohio. Submitted January 13, 1949.

**The Aureomycin (Duomycin, Lederle) used in this study was supplied by courtesy of Dr. S. M. Hardy, Lederle Laboratories Division, American Cyanamide Co., Pearl River, N. Y.

TABLE I

Summary of Clinical and Laboratory Findings in Urinary Tract Infections Treated with Aureomycin

Patient	Sex	Age	Organism cultured from urine	Diagnosis	Previous therapy	Symptoms	Dosage of Aureomycin	Result
J.A.	M	63	E. Coli Staph.	Diabetes Chronic prostatitis cystitis	Penicillin Sulfadiazine	Frequency Burning Cloudy urine	0.5 gm. q. 8 hrs. (7 days)	Symptom free Clear urine Cluture, no growth
E.S.	F	38	E. coli	Chronic trigonitis	Sulfadiazine	Urgency, frequency, burning 5 mos. duration	0.25 gm. q. 6 hrs. (5 days)	Symptomatic relief No recurrence 30 days.
M.H.	M	54	E. coli	Atonic bladder following colon surgery	Penicillin	Fever, bladder pain. Retention catheter "milky" urine	0.5 gm. q. 8 hrs. (7 days)	Afebrile, clear urine Symptomatic relief Recurrence in 2 weeks again controlled, remains on small maintenance dosage
J.C.	F	42	None obtained	Chronic cystitis	Sulfadiazine Penicillin	Burning & frequency 4 mos. Pus in urinary sediment	0.25 gm. q. 6 hrs. (7 days)	Symptomatic relief Pyuria absent.
L.A.	M	54	E. coli Staph.	Chronic pyelo-nephritis	Streptomycin (toxic reaction) Sulfadiazine Penicillin	Low grade fever, malaise Burning	0.5 gm. q. 8 hrs. (10 days)	Symptomatic relief Recurrence 5 days later controlled only if therapy continuous
M.W.	F	36	E. coli	Chronic pyelitis following pregnancy	Streptomycin Sulfadiazine	Recurrent fever, burning Pyuria	0.25 gm. q. 6 hrs. (7 days)	Symptom free No recurrence to date.
A.A.	F	43	E. coli Staph.	Chronic trigonitis	Sulfadiazine	Urgency, Burning Few R.B.C. in urinary sediment	0.25 gm. q. 8 hrs. (5 days)	Symptomatic relief
A.F.	M	72	E. coli	Pyuria following prostatec-tomy	Penicillin Sulfadiazine	Minimal symptoms plus cloudy urine	0.5 gm. q. 8 hrs. (10 days)	Clear urine Culture sterile
R.C.	M	54	E. coli	Atonic bladder following colon surgery	Penicillin Sulfadiazine	Dribbling 300 cc. residual urine Formation of bladder stone	0.5 gm. q. 8 hrs. (7 days)	Symptomatic relief Pyuria absent Stones later crushed and removed.
J.K.	M	60	E. coli	Chronic prostatitis plus acute pyelitis	Penicillin	Fever 103°F malaise Burning Pyuria	0.5 gm. q. 8 hrs. (7 days)	Afebrile in 24 hrs. Symptomatic relief Clear urine

cases persisted for a considerable time after the medication was stopped.

The cases in this study represent a heterogenous group selected for the reason that our interest lay in noting the response to the drug of a variety of urinary tract infections where E. coli was the predominating organism. It is in the control of this type of infection that we have previously experienced the greatest difficulty. Re-invasion on the urinary tract by the infection may occur following the withdrawal of the drug if adequate drainage is lacking or if the original focus of infection remains. In such an event re-treatment may be necessary. There is evidence that some of these infections may be kept under control by more prolonged administration of the drug in reduced dosage.

SUMMARY AND CONCLUSIONS

The use of aureomycin in the treatment of a small group of patients with chronic and resistant bacillary infections of the urinary tract is presented. Encouraging results were obtained in the use of this new antibiotic.

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Some Fundamentals in Water and Electrolyte Balance

WALTER G. MADDOCK, M. D.

SO MUCH dependence is placed upon intravenous fluids in the care of surgical patients that a knowledge of their proper use is essential. In the majority of cases the requirements are simple and easily met, but for those with serious disease conditions a selection of the amount and kind of fluid to administer on the basis of the best available knowledge is needed to aid biochemical functions and not embarrass them. It is quite possible to do the latter, and it probably happens occasionally on the best of regulated services. The answers to all the problems are not available and while we are doing better there is still much to learn.

The following is a review of some of the fundamental considerations in this therapy:

WATER

About 70 per cent of the total body weight[1, 2, 3] is water and this is distributed in two physiologic compartments, 50 per cent in the intracellular and 20 per cent in the extracellular. Water moves freely between these two compartments in response to osmotic forces, potassium largely providing the effective osmotic pressure in the intracellular compartment and sodium largely for the extracellular. The distribution of these two bases is the chief factor controlling the distribution of body water.[2]

The components of normal daily water exchange with some average figures are shown in Table 1. As can be seen, water becomes available

Table 1

Available Water	cc.	Excretory Water	cc.
1. Fluids drunk	1200	1. Water vaporized	1200
2. Water from food		2. Water of stool	100
a. Water content	1000	3. Water of urine	1200
b. Water of oxidation	300		
	2500		2500

Table 1. COMPONENTS OF NORMAL WATER EXCHANGE

from fluids drunk and from food eaten, the latter providing both its water content and water of oxidation as it is burned for energy. In this way the ordinary solid foods of the diet, meat, vegetables, fruit, et cetera, yield about nine-tenths of their weight as water and furnish an important part of the daily total.[4]

On the excretory side two important processes require considerable daily volumes. Water is vaporized from the skin and lungs as part of the heat dissipating mechanism, and without visible sweating average-sized adults will use 1000 to 1500 cc. daily for this purpose.[5] Since an increase in the vaporization of water from the skin surface is the safety valve of heat dissipation, hot humid environments may result in the use of up to 5 liters per day by this process. It is important to remember that the vaporization of water goes on even when available water is low in amount and other water needs therefore suffer greater restriction.

The second important process by which water is spent is through the kidneys employing water to excrete waste materials in solution, and they do so with the amount available after the vaporization loss has been cared for. In this way the urine output is in most cases a good index of a satisfactory water balance.

The third normal water loss, that of the stool, is insignificant and is seldom much more than 100 cc. daily.

THE ESTIMATION OF DAILY WATER REQUIREMENTS

To prevent a rapid depletion of the water in the body a knowledge of the water needed for 24-hour periods is fundamentally important. An adult taking nothing by mouth has about 300 to 500 cc. of water available from the water content and water of oxidation of his own protein, fat and carbohydrate burned for energy.[1, 3] It is better not to count on this water but to provide the patient with sufficient to cover the two continuous daily losses, i.e., the water spent for vaporization and for urine.

From special studies it is known that a normal adult patient in a comfortable environment will vaporize about 1000 to 1500 cc. per day.[4] For patients having an extra load on the heat dissipating mechanism, as by fever, hyperthyroidism or a hot, humid environment, one should allow 2000 cc. for this process. For continued marked perspiration much more water may be so lost and figures up to 5000 cc. daily

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have been obtained in the uncomfortable top weather conditions.[6] By noting the presence and degree of sweating and the coincident low urine output the careful observer will have no difficulty in allowing more water for the vaporization process.

Water for urine is obtained by giving an amount in excess of that used by the vaporizing process, and it is fundamentally important to know how much to allow for a satisfactory urine output. Lashmet and Newburgh[7] have furnished pertinent data by their study of the minimal amount of water needed by individuals with normal and with diseased kidneys to excrete a certain amount of waste material. From their work a calculation was made of the minimal amount of water needed to excrete 35 gm. of body wastes, which is about an average daily amount in health. From the results, shown in Table 2, it is apparent that about 500 cc. of

Table 2*

Status of Kidneys	Maximum concentrating ability Specific gravity	Minimum water needed c. c.
Normal	1.032 to 1.029	483
Diseased**	1.028 to 1.025	595
	1.024 to 1.020	605
	1.019 to 1.015	850
	1.014 to 1.010	1439

*Calculated from Lashmet and Newburgh (7)
**Chronic nephritis, pyelonephritis, renal tuberculosis, et cetera

Table 2. THE MINIMAL AMOUNT OF WATER NEEDED TO EXCRETE 35 GRAMS OF WASTE MATERIALS

urine is the very minimum for daily kidney function under forced conditions. This figure is supported by Gamble[3] who found 500 cc. of urine to be the obligatory outgo of healthy young men without food or water on life raft experiments.

This 500 cc., however, is too low an output of urine to be satisfactory for many reasons. It occurs when the kidneys are working at maximum concentrating ability, as shown by a urine specific gravity of about 1.030. Since most body functions are not maintained at top speed, more water is needed to allow for kidney function at moderate working capacities, which will produce moderate urine specific gravities. Also, the sick patient may have more than the average amount of waste materials to excrete, such as a greater amount of nitrogen from an increased breakdown of protein or ketone acid formation from a lowered carbohydrate metabolism. A not infrequent additional difficulty in sick patients is a temporary or permanent decrease in the concentrating ability of the kidneys.

A further view of the inadequacy of low urine output comes from experimental studies and clinical observations on dehydration. Some adult individuals with daily urine volumes close to 500 cc. are actually dehydrating. The following figures should be observed carefully. J. N.,[8] a healthy medical student, underwent a dehydration experiment. The water content of his 3000 cal. diet was very low. He received no fluids for 3 days and 514 cc. of water the fourth day to help him swallow the dry food. For the four days he was able to excrete successive daily urine volumes of 472 cc.-sp. gr.-1.031, 481 cc.-sp. gr.-1.032, 442 cc.-sp. gr.-1.037, and 446 cc.-sp. gr.-1.038. During this period he lost 4053 gm. of body water, his blood nonprotein nitrogen increased from 31.0 to 45.7 mg. per cent, and all of the common symptoms and signs of serious dehydration were present. From this example the seriousness of the situation when a patient excretes only 200 to 300 cc. of urine a day is apparent.

A satisfactory urine output for the majority of surgical patients is 1000 to 1500 cc. per day.[9] As can be seen from Table 2, it is two to three times the minimum and will allow for a moderate specific gravity in most instances. Wangensteen[10] and Blalock[11] also recommend these volumes as satisfactory urine outputs for the average surgical patient.

Surgeons are missing something by not paying more attention to the concentration of the urine. A specimen with a specific gravity close to 1.030 denotes excellent kidney function, and conversely an output of low fixed gravity comes from poor function. Table 2 shows that increasingly greater amounts of urine are needed to do the work as the specific gravity becomes less. The individual with very poor concentrating ability may be able to get rid of his daily waste materials and keep out of trouble with urine volumes of 1500 to 3000 or more cubic centimeters daily. Similarly, individuals with a retention of nitrogenous wastes or excesses of electrolytes and organic acids may need 1500 to 3000 cc. of urine daily to correct these abnormalities.

In general the daily water requirements of surgical patients can be summarized[9] as in

Table 3

Simple Case	cc.
Water for vaporization	1000 to 1500
Water for urine	1000 to 1500
	2000 to 3000
Complicated Cases	cc.
Water for vaporization: (with sweating, fever, hyperthyroidism, or hot, humid environment)	2000+
Water for urine	1500+
	3500+

Table 3. DAILY WATER REQUIREMENTS OF SURGICAL PATIENT

Table 3. For the special circumstances discussed in previous and later paragraphs larger volumes may be needed.

THE KIND OF FLUID FOR DAILY WATER REQUIREMENTS

It should be clearly understood that the kind of parenteral fluid needed to provide water for

vaporization and for urine is not salt solution, but water, with dextrose and/or a protein hydrolysate added for nutritional needs.

Dextrose Solutions, 5, 10 or 15 Per Cent in Water: These solutions are important for the patient taking insufficient water or food by mouth. The 5 and 10 per cent concentrations are most commonly used and they provide water which appears to be available for all purposes just as if it were taken by mouth,[3, 12] and the carbohydrate may be stored or burned for energy. Advantages may be thus gained preoperatively, during the operation, and postoperatively, since among other benefits the glycogen content of the liver can be increased[13] and dextrose is an excellent cardiac stimulant and food for the myocardium. It has been shown in volunteer subjects deprived of water, food and salt that 100 gm. of carbohydrate daily decreases the rapidity of dehydration.[3] This excellent effect is considered to be due in part to water produced by the oxidation of the carbohydrate, to the reduced catabolism of protein, and possibly to the avoidance of ketone acid formation which may well play an important role in dehydration.

Most intravenous solutions for parenteral use contain at least 5 per cent dextrose, and a total of 2000 to 3000 cc. of such solution per day provides 100 to 150 gm. of carbohydrate and 400 to 600 calories. This is far below daily caloric needs and 10 per cent dextrose solution is often used although it tends to irritate veins and produce phlebothrombosis. The 10 per cent solution does not produce dehydration;[12] 3000 cc. of it yields 300 gm. of carbohydrate and approximately 1200 Cal., which is a great improvement, yet only about half of the calories required for an average-sized patient resting quietly in bed.[14] For greater caloric value the 15 per cent solution may come into use, particularly for patients with severe liver damage and malnutrition.

Dextrose solutions have no specific value in shock, but along with the properly indicated blood, plasma and electrolytes, dextrose should be given for its general supportive effect.

Dextrose solutions are of no value in replacing electrolyte losses. Excellent examples of circulatory failure and shock have been noted in instances where salt-containing fluids were being lost, as by vomiting or enterostomy drainage, and only dextrose solutions were being given intravenously. This is against the general principle that parenteral fluid therapy should provide as nearly as possible the kind of material lost.

Dextrose solutions supply easily available water for countless internal fluid adjustments, and for the replacement of water used for vaporization and kidney function. A good supply of available water is of tremendous importance to the kidneys since it enables them in health and aids them in disease to guard the proper concentration of substances in solution in the blood. This will be emphasized later.

Protein Hydrolysate Solutions: These solutions also provide available water, and in addition some protein and carbohydrate. As manufactured some also contain 2 gm. of NaCl per liter and others do not, so the preparation label should be read to learn exactly what is being given. The author selects a protein hydrolysate solution when protein is particularly needed. It is useful in the preoperative prepartion of the undernourished patient, and for all those not likely to begin eating sufficient food soon after operation.

DAILY ELECTROLYTE REQUIREMENTS

There is no data on hand to prove or disprove the thought that generally a few grams of sodium chloride should be given daily to patients having no abnormal electrolyte loss but requiring nutritional substance parenterally. It is true that if a patient can take food orally his normal taste desires would include some sodium chloride. It is not illogical then if sustenance depends on parenteral methods to give a small amount of sodium chloride daily. Butler and Talbot[15] place the normal daily allowance at 1 gm. for infants, 3 gm. for children and 6 gm. for adolescents and adults. Conveniently about 5 gm. of sodium chloride can be given daily to adults by 500 cc. of physiological saline or Ringer's solution, or a liter can be given every second day.

As suggested by Coller, et al's., study of salt intolerance in the immediate postoperative period,[16] sodium chloride should not be given for two days postoperatively unless specifically indicated by a considerable gastro-intestinal fluid loss. Similarly, when other factors of abnormal water and electrolyte retention are present: malnutrition, sepsis, severe hemorrhage, serum loss as from burn surfaces, renal, hepatic or cardiac damage,[17] the daily electrolyte allowance may well be further reduced or dispensed with for several days. Moyer thought[18] the incidence of postoperative pulmonary complications after upper abdominal operations was higher, especially in the aged, when maintenance doses (5 to 9 gm. daily) were infused than when no salt was given unless specifically indicated.

ELECTROLYTES AND DEHYDRATION

Dehydrated patients present a special problem in fluid balance because they have a deficit, and to make up for this deficit they need: (1) More than daily maintenance amounts of fluid; and (2) water plus electrolytes.

Electrolytes are of great consequence to the body[2] for they form a most important part of the fluids that diffuse through and around all tissue, and they are responsible for a large percentage of the total osmotic pressure of the body fluids. In the extracellular compartment,

which can be subdivided into the vascular and the interstitial spaces, sodium, chloride and bicarbonate ions are of greatest abundance while potassium, calcium, magnesium, sulphates and phosphates are in lesser amounts. In dehydration the loss of fluid volume is greater in the extracellular compartment, though not entirely so, and considering that its fluid is the circulating medium that brings every kind of nourishment to the cells, takes away all waste materials, provides the digestive juices, and furnishes water for heat dissipation and for urine, it is not surprising that an appreciable loss of this fluid produces profound effects.

THE SYMPTOMS AND SIGNS OF DEHYDRATION

To be alert to recognize dehydration is to be aware of the possibilities and to look for the early symptoms and signs. The chief candidates are patients losing important amounts of gastro-intestinal fluids, or those with the chemical disturbances of diabetic coma. Non-diabetic ketosis, nephritis, burns, Addison's disease and heat prostration and heat cramps are other causes not infrequently seen.[2] The presence of the severe symptoms and signs of dehydration so often indicate the failure to make an early diagnosis and to employ proper treatment.

A number of variables are important in the symptoms and signs of dehydration. The more rapid the deficit the more acute the symptoms. With slowly developing deficits there may be few symptoms and the surgeon may fail to recognize quickly the changes occurring over several days. The poorer the general condition of the patient and the older the patient the more severe the reaction.[18]

The way in which the dehydration develops also makes a difference. In 1935, Kerpel-Fronius[19] demonstrated in rabbits two types of dehydration: (1) That due to a shortage of water but not accompanied by a corresponding loss of salt, and characterized chiefly by thirst; and (2) dehydration due to a primary loss of electrolytes which produced a more profound dehydration and was characterized by circulatory disturbances and collapse. McCance[20] and Nadel, et al.,[21] studied the types in experimental human subjects and again noted the different responses. With no or very little water intake there is marked thirst and a dry mouth and tongue, oliguria with high urine specific gravity if renal function is good, a slow increase in the nitrogenous wastes in the blood, hallucinations, disorientation and coma as the deficit becomes extreme. Plasma protein and hematocrit concentrations may not be significantly altered until very late.

In humans, the dehydration of electrolyte fluid loss with plenty of water intake is an experimental set up, or an example in a patient of the thoughtless replacement of an electrolyte fluid loss by only water and dextrose. With a good water intake such individuals are not thirsty.

Most clinical instances of dehydration are a combination of an electrolyte fluid loss and a water deficit, since the patient who is vomiting is usually not drinking. The result is largely an extracellular fluid loss. When slight or of moderate degree there is some apathy, weakness, somnolence, anorexia, nausea and variable changes in systolic blood pressure. With severe dehydration the above signs and symptoms are increased until finally circulatory collapse with blood pressure down to shock levels appear. The skin and tongue are dry and wrinkled, the muscles feel putty like, the eyeballs are soft, and the body temperature may be subnormal. As the dehydration progresses the hematocrit and plasma protein concentrations usually increase while the electrolytes decrease. Urine output is usually quite low and blood urea or non-protein nitrogen levels are increased. All these findings are more severe with rapidly developing deficits, and less obvious with the slowly occurring variety.

CHEMICAL STUDIES

The chemical studies usually made on patients with dehydration are the plasma CO_2 combining power, the plasma or whole blood chlorides, the blood non-protein or urea nitrogen and the plasma proteins. Lately, faster methods have made serum sodium studies possible, which is a real advance, and a renewed awareness of the importance of potassium has resulted in blood potassium studies. Some pertinent comments on these laboratory data and their application follow:

Plasma CO_2 Combining Power: Normal 55-65 volumes per cent. This test is the simplest and most dependable measurement for the presence of alkalosis or acidosis[3] and is carried out by determining the volume of CO_2 released by adding strong acid to a known amount of plasma in the Van Slyke burette. Changes in the CO_2 volume from the normal may be due to two possible variables:

1. Carbonic Acid (H. HCO_3). This is formed from the carbon dioxide of body metabolism and its normal plasma concentration depends upon the respiratory mechanism removing CO_2 through the lungs. Important disturbances of respiratory control are relatively infrequent. An alkalosis due to carbonic acid deficit has been noted with overventilation of a voluntary nature, or with encephalitis, hysteria or to a mild degree in febrile states.[22] The acidosis of carbonic acid excess has been found in some cases of emphysema, asthma and depression of breathing by opiates, in which gas exchange in the lungs is markedly hindered.[22]
2. Base bicarbonate (B. HCO_3). This varies with electrolyte disturbances such as pro-

duced by a loss of gastro-intestinal tract fluids through vomiting, continuous gastro-duodenal suction, biliary and pancreatic fistulae, ileostomy drainage and diarrhea. Occasionally medication such as large amounts of sodium bicarbonate or sodium phosphate disturb electrolyte balance. Important changes also result from the retention of phosphates and sulfates in nephritis, and ketone acids in diabetes and the quick ketosis of children. In these chemical disturbances alkalosis or alkali excess is indicated by a CO_2 combining power of 75 or 80 volumes per cent or above,[22] and acidosis or alkali deficit of a significant degree is indicated by a CO_2 combining power of 40 volumes per cent or below.[22] A further discussion of the factors producing each is given later.

In the diagnosis of alkalosis or acidosis[3, 22] a plasma CO_2 combining power determination suffices when there is a patient history of gastro-intestinal fluid loss, nephritis or diabetes. In such "metabolic" disurbances, which make up the great majority of the clinical cases seen, a high CO_2 combining power dependably indicates alkalosis and a low value acidosis. When, as occasionally occurs, "respiratory" factors from any cause produce underventilation or overventilation, and thus alter plasma carbonic acid concentrations, the CO_2 combining power changes have the reverse significance, a high value indicates acidosis and a low value alkalosis. Therefore, when respiratory factors are present a plasma pH should be run and correlated with the CO_2 combining power to indicate the proper reaction disturbance. A recent case emphasized this need. Both metabolic and respiratory conditions were present since an inlying Wangensteen tube was continuously removing gastro-intestinal fluid and the respiratory rate was markedly increased because of abdominal distention and pneumonitis.

Serum Sodium: Normal 326 mg. per 100 cc. or 142 meg./L. Serum sodium values give direct information on the predominant basic ion in extracellular fluids and are important determinations in all body electrolyte studies. Unfortunately the chemical analysis of a serum sodium value takes considerable time, so this test has been used mainly in experimental studies and seldom in general clinical work. Recently flame photometer methods have been developed which take much less time[23] and it is hoped that simple, reliable equipment will soon be available to make this study possible in most hospital laboratories.

Serum Potassium: Normal 20 mg. per 100 cc. or 5 meq./L. Recently Govan and Darrow[24] have re-emphasized the importance of potassium in dehydration states. By its addition to the commonly used NaCl solutions they were able to reduce the mortality of infants with infectious diarrhea from 17 in 53 to 3 in 50. Potassium is, therefore, discussed later in this paper.

Plasma Chlorides: Normal 560 mg. per 100 cc. expressed as NaCl. As straight Cl: 365 mg. per 100 cc. or 103 meq./L. This determination is an important one, particularly in patients who have lost significant amounts of gastro-intestinal tract fluids. However, there are some special aspects to remember about chloride studies, as follows:

1. Chloride loss receives considerable attention, possibly more than it merits when the concurrent loss of other substances is considered. Actually sodium loss is relatively more important than chloride loss, but sodium studies are much harder to do and, therefore, chloride studies are run and receive more attention. In general a lowered plasma chloride is one indication of an electrolyte loss which means importantly an extracellular fluid loss.

2. A lowering of the plasma chlorides reflects a fall in the chloride content of other body fluids. The data are not always quantitative but from work on dogs vomiting from intestinal obstruction White and Bridges[25] concluded that chlorine is lost from the body in amounts directly proportional to the decrease in chlorine content in the blood, and the total dechlorination of the body corresponds closely to the salt recovered in the vomitus and urine. A low plasma chloride value in a patient with a history of the abnormal loss of gastro-intestinal tract fluid from vomiting or upper gastro-intestinal tract aspiration roughly reflects the extent of the body chloride loss.

3. A plasma chloride value cannot be used as an indicator of the excessive administration of a sodium chloride solution to the seriously ill patient. The water and electrolytes administered to these patients pass quickly into the interstitial spaces and result generally in a hyperhydration and edema rather than hyperchloremia.[26, 27, 28] It has been noted that if the general condition of the patient improves, often meaning an improvement in the plasma protein level, a shift may occur in the electrolyte distribution and plasma chlorides increase to normal without further salt administration.[41, 47]

4. As mentioned in the previous paragraph, the failure in a seriously ill patient to raise a low plasma chloride level with a sodium chloride solution is most commonly associated with the salt solution going to the interstitial spaces and producing hyperhydration and edema.[43, 46] Occasionally, however, a sick patient will excrete the salt in

the urine even though the plasma concentration remains below normal. The reason for this is not entirely clear, but there is some evidence that the kidneys have temporarily lost their ability to retain needed electrolytes. Also, the lower plasma chloride level may be quite proper for the patient at that particular time. The next paragraph discusses this briefly.

5. While moderately or seriously ill, most patients do not maintain plasma chloride levels at the normal figure, but at a somewhat lower level. This has been noted in burns and other diseases where an abnormal water and electrolyte shift may have taken place.[9] The electrolytes may have gone to a general accumulation of edema fluid or to a local collection about an injured part. A patient is probably not suffering from a lack of chlorides with a plasma level down to 500 mg. per cent, and often while seriously ill sodium chloride administration will not raise the value to the normal level.[30] In these cases the history, physical findings, other laboratory data and the general condition of the patient should be considered before more salt is administered. For example, one should be particularly careful about giving saline solutions to patients whose plasma chloride level is moderately low but who have no history of the abnormal loss of electrolytes, as by vomiting, et cetera. Such patients may have ascites, which is taking sodium chloride from other parts of the body to make the ascitic fluid, and the plasma chloride level is likely to be below the normal of 560 mg. per cent.[26, 32, 33] If a sodium chloride solution is given it may elevate the plasma electrolytes temporarily, but more ascitic fluid will be promptly formed and the plasma level will drop again.[26, 32, 33]

6. A word about whole blood chloride studies. These values vary with the degree of anemia and the test has been criticized for that reason. Hoffman and Osgood[23] recently have emphasized the marked variations that occur with different hemoglobin concentrations or hematocrit readings and point out the need for a chart of these interrelations in interpreting whole blood chloride values. Their conclusion was that the whole blood chloride test should be abandoned and plasma chloride studies substituted.

Blood Non-Protein Nitrogen: Normal 35-40 mg. per cent. It is well to know by this test just how able the kidneys have been in performing one of their important functions. Retention of waste materials is commonly found with the oliguria of dehydration and two factors are generally accepted as important in its production: (1) insufficient water for kidney function; and (2) increased destruction of protein associated with the disease. There may also be a temporary decrease in the concentrating ability of the kidneys at this time so that with a given amount of available water less waste materials are excreted.[8]

Plasma Proteins: Normal: Total 7.1 mg. per cent, albumin 4.1 mg. per cent, globulin 2.7 mg. per cent. These are importantly concerned with water and electrolyte shifts in the body. With low plasma proteins there is a striking tendency for the abnormal retention of fluids and edema formation is common. Low plasma proteins occur with malnutrition, infection, hemorrhage, profuse serous drainage, renal, cardiac and hepatic damage, and after long operations, so the surgeon is frequently confronted with this condition.[17, 34, 35, 36, 37] Retention of fluids should be thought of as occurring generally through interstitial spaces, and locally at injury and operative sites. In the latter regard, Mecray, Barden and Ravdin[38] have described obstruction at gastro-enterostomy stomas from edema associated with low plasma proteins.

Moore and Van Slyke[39] have stated the following critical levels at which fluids tend to be retained: total plasma proteins 5.5 mg. per cent, plasma albumin 2.5 mg. per cent. These are good figures to remember, but it has been noted by many workers that sodium chloride solutions may be retained and edema develop in the seriously ill patient when plasma proteins are normal or just slightly below normal.[17, 30, 35, 37, 40]

ESTIMATES OF THE DEGREE OF DEHYDRATION AND THE AMOUNT OF FLUID NEEDED FOR ITS CORRECTION

From a rough estimate or an approximate of the degree of dehydration one can obtain some idea of the amount of fluid needed for its correction. Both the amount and the kind will vary somewhat with each case, and dependence must still be placed on the kidneys given a good supply of water to exercise some selection of the electrolyte ions needed and to excrete the excess, thus re-establishing a satisfactory water and electrolyte balance.

The "estimate" or "working approximate" of the initial amount and kind of fluid to give is arrived at through a consideration of the history of the dehydration, how it developed, its duration, the possible volumes lost, whether any oral fluid was retained, and the thirst of the patient. From the physical examination, note is made of the general appearance of the patient, the degree of inanition, evident loss of weight, dryness of the mouth and tongue, inelasticity of the skin and muscles, sunken eyes, and the presence of edema. Laboratory studies tell about the volume and specific gravity of the first

urine specimen, the erythrocyte and leukocyte count, the hemoglobin and hematocrit levels and the plasma chloride, protein, carbon dioxide combining power and the blood non-protein nitrogen. This is a long list and more could be added, yet for the seriously dehydrated patient the good observer may use all of them for the initial estimation of fluid needs. The result of the initial fluid administration is shown by the general response of the patient and the changes in the urine and subsequent blood studies.

From observations on animals and patients losing gastro-intestinal fluid, attempts have been made to place electrolyte administration on a quantitative basis. In 1923 Haden and Orr[41] recommended the administration of 1 gm. of sodium chloride per kilogram of body weight as the initial dose of salt in the treatment of the toxemia of intestinal obstruction. While the salt restored body water and electrolytes rather than treated toxemia, theirs was the first attempt to place salt administration on a quantitative basis. In 1937, Falconer and Lyall[42, 43] concluded that "in hypochloremia about 20 grammes (15 to 30 grammes) of salt are required on the average to raise the plasma chlorides by 100 mg. per 100 cc."

In 1938, Coller, Maddock, et al.,[31] from a quantitative study of saline administration to surgical patients with hypochloremia from electrolyte fluid loss suggested for clinical purposes that for each 100 mg. per cent the plasma chlorides need to be raised to reach the normal (560 mg. per cent) the patient should be given 0.5 gm. of sodium chloride per kilo of body weight. In 1942, Power, Pedersen and Maddock[30] reported further clinical experience with this formula on patients admitted to the hospital with depleted body electrolytes, mainly as a result of vomiting. Their conclusion was that the replacement formula was satisfactory in the patients of good or fair general condition who had suffered an acute or recent loss of gastro-intestinal fluid. Patients who had a more chronic illness and whose general condition was poor frequently failed to utilize the sodium chloride in a normal fashion, most commonly depositing the salt and water in interstitial compartments and thus not increasing their plasma electrolytes to normal, but occasionally excreting the salt in the urine even though the plasma concentration was low. These patients of more chronic illness often did not have a history of recent or severe vomiting and their lowered plasma chlorides seemed to have resulted from a long-standing or chronic sodium chloride deficiency or loss. Also, these patients commonly had one or more of the factory setting the background for the development of edema[17] that is, general malnutrition, low plasma proteins, sepsis, severe hemorrhage, profuse serous drainage and severe renal or hepatic damage. Since considerable caution has to be used in giving more than moderate amounts of saline solution to such patients and because the plasma chloride level is not always a good index of electrolyte depletion Coller, Moyer, et al.,[16] have advised that this formula not be used. The author occasionally uses the formula in cases of electrolyte depletion from vomiting, but has modified the 0.5 gm. figure to 0.33 gm. per kilogram of body weight for each 100 mg. the plasma chlorides need to be raised to reach the normal of 560 mg. per cent.

A second estimation approach is possible. Years ago Rubner[44] stated that in starvation an animal can lose practically all of its glycogen and fat, half of its body protein, 40 per cent of its total body weight, and still live, whereas the loss of 10 per cent of the water content results in serious disorder, and the loss of from 20 to 22 per cent results in death. Studying human subjects Maddock and Coller[8] found that all of the common clinical findings of serious dehydration were present when individuals had lost an amount of body fluid equal to 6 per cent of their body weight. They suggested the use of this figure in estimating the amount of fluid need to overcome dehydration deficits. From data on animals and patients, Darrow[2] "estimates that about one-third (8 per cent) of the extracellular electrolyte is lost in marked dehydration, and for restoration in such cases he estimates an amount of salt present in physiologic solution of sodium chloride equal to one-fifteenth (6.6 per cent) to one twelfth (8.3 per cent) of the body weight (about 70 cc. per kilogram of body weight) is required. Smaller amounts are needed in mild cases."

Using the body weight data[8] a calculation of the amount and kind of fluid to be given during the first 24 hours to a 60 Kg. patient dehydrated because of gastro-intestinal fluid loss would be as follows:

	cc.	
Water for vaporization	1500	5 or 10% dextrose in water or protein hydrolysate solution
Water for urine	1500	
Electrolyte fluid for dehydration: 6% of 60 Kg.	3600	5% dextrose in physiological saline or Ringers' solution or lactate-Ringers' solution as indicated
	6600	

It should be emphasized that larger or smaller amounts of fluid might be needed depending upon the degree of dehydration, the size of the patient, the presence of fever requiring more water for vaporization, the need for more water for kidney function as a result of the presence of a previous retention of waste materials and/or a decreased concentrating power of the kidneys, or a continued abnormal loss of fluid as by vomiting.

Since the volume of fluid needed to correct

dehydration is often large in amount, it should be given slowly, usually over a 24-hour period. The rate per hour should be written in the order book at the same time the amount and kind of fluid is specified.

COMMON ELECTROLYTE SOLUTIONS

The composition of the solutions commonly used to furnish water and electrolytes and prevent or treat dehydration is given in the following paragraphs, along with some pertinent comments. Specific examples calling for their use are discussed later.

Physiologic Solution of Sodium Chloride: NaCl 9.0 gm. per liter; or Na 155 meq., Cl 155 meq. per liter. Thus in milliequivalents physiologic solution of sodium chloride has the same amount of sodium as chloride, but compared to the concentration of these substances in blood plasma, Na 142 meq./L, Cl 103 meq./L, it contains relatively more chloride. It has had the most widespread use for replacing deficits of extracellular fluid and treating both alkalosis and acidosis.[18, 45] The kidneys with a good supply of water have been depended upon to select the ions needed and excrete the surplus. This works well in many instances but at present more thought is given to the individual need for either more acid or basic ions and a solution is now selected to more nearly fit that need. The kidneys are thus saved from having to make all the selection and do extra work when function may be poor because of the disease conditions. Also, the shift of fluid between the intracellular and extracellular compartments is considered to be more in the right direction when fluids balanced to meet the needs are given.[45]

Physiologic solution of sodium chloride should be used for cases in which the choride loss is greater than or about equal to the sodium loss.

Ringer's Solutions: NaCl 8.6 gm., KCl 0.3 gm., $CaCl_2$ 0.33 gm. per liter; or Na 148 meq., K 4 meg., Ca 6 meg., CL. 158 meg. per liter. The indications for the use of this solution are the same as those given for physiological sodium chloride. Although it has a small amount of potassium and calcium chloride in addition to a good quantity of sodium chloride, it is difficult to prove from clinical use that it has any advantage over physiologic solution of sodium chloride. It may have a little less tendency to produce edema than the latter.[87] However, because in dehydration there is usually some loss of calcium and potassium besides sodium and chlorides ions the author prefers it to the physiological sodium chloride solution. Ringer's solution does not contain sufficient potassium to replace a serious deficiency of that substance.

Lactate-Ringer's Solution: Na lactate 2.5 gm., NaCl 6.0 gm., KCL 0.3 gm., $CaCl_2$ 0.2 gm. per liter; or Na 125 meq., K 4 meq., Ca 4 meq., Lac. 22 meq., Cl 111 meq. per liter. Lactate-Ringer's solution is desirable in practically all cases where acidosis is present or possible. The 2.5 gm. of sodium lactate in this solution provide an excess of sodium after the lactate is metabolized. It has been pointed out that with serious impairment of liver function the splitting off of the lactate radical, which is part of the metabolic process, may be interfered with[46] so in such cases sodium bicarbornate is a better substance where an excess of sodium is needed.

Hypotonic Solutions of Sodium Chloride: Sodium chloride 4.5 to 6.0 gm. per liter; or Na 78 to 103 meq., Cl 78 to 103 meq. per liter. Coller, et al.,[16] recently have advocated the greater use of these solutions because of the relatively high incidence of "salt intolerance following a general anesthesia." In order to provide more freely available water, and not to draw water from the intracellular compartment, they[45] state that "if intravenous infusion is indicated in the postoperative care of the surgical patient, hypotonic solutions, 0.45 per cent NaCl, or better 0.38 per cent NaCl plus 0.11 per cent $NaHCO_3$, should replace the 'isotonic solutions' commonly in use."

SPECIAL SOLUTIONS FOR SEVERE ALKALOSIS AND ACIDOSIS

It has long been suggested by some experts that in the extreme alterations of acid-base balance the initial treatment should be a reduction of the severe alkalosis or acidosis to a moderate or mild alkalosis or acidosis, and the substances of this section have been used for that purpose. Immediately after the extreme of the compositional change has been corrected, then physiological saline or Ringer's solution or lactate-Ringer's solution as indicated should be given to correct the remaining water and electrolyte deficiency. In this way the most needed ions are immediately provided and the kidneys which may well have a disturbance in their selective function then have a lesser load.

Hydrochloric Acid: Provides chloride ions. Used for severe alkalosis. Cullen[47] proposes the use of HCl for an alkalosis of over 90 volumes per cent of plasma CO_2 and makes up the solution by the following rule: "The amount of concentrated HCl (36 per cent)=Vol. per cent of CO_2 excess (over 70) x 0.028 x wt. (kilo). Add the acid to 0.9 per cent NaCl solution so that there is never more than 5 cc. of concentrated acid per 100 cc. of saline." Moyer[18] presents this calculation as follows: Take 0.063 cc. of concentrated HCl (36 per cent) per kilogram of body weight for each milliequivalent the base bicarbonate is above 30 meq. per liter of plasma; dilute with 0.9 per cent NaCl solution so that not more than 5 cc. of concentrated acid is present in 100 cc. of saline. This solution is then given slowly and injection stopped if dyspnea appears. If the necessary laboratory data are not

available and severe alkalosis is present, Moyer advises giving M/100 HCl until the carpopedal spasm and the hypopnea are relieved.

Ammonium Chloride: Provides chloride ions since the ammonia is largely converted to urea or is excreted in the urine. Used for severe alkalosis. An 0.9 per cent solution is isotonic and in an emergency when the usual laboratory data are not available, Moyer[18] states. NH_4Cl may be given until the carpopedal spasm and the hypopnea are relieved. Zintel, Rhoads and Ravdin[48] have treated surgical patients with severe alkalosis with a 2 per cent NH_4Cl in 0.9 per cent NaCl solution intravenously and have noted that it was effective in lowering the serum CO_2 at the rate of approximately one volume per cent for each gram administered to adults of medium size and weight.

Sodium Bicarbonate: Provides sodium ions since the bicarbonate is excreted or readily decomposed to CO_2 and blown off through the lungs. Used for severe acidosis.[49] A 1.3 per cent solution is isotonic. Hyperpnea is commonly used as an indicator for its use, and Moyer states the 1.3 per cent solution may be given intravenously until the hyperpnea and dyspnea are relieved, which usually does not take more than 2 liters for an adult. When laboratory data are available in a case of severe acidosis Moyer[18] uses 60 mg. of $NaHCO_3$ per kilogram of body weight of the 1.3 per cent solution for each milliequivalent the base bicarbonate is below 25 meq. per liter of plasma.

Another method of $NaHCO_3$ calculation is presented by the equation of Hartmann and Senn:[50]

$$mM = \frac{(60 - CO_2)\ 0.7\ W}{2.24}$$

In this equation, mM is millimols of sodium bicarbonate or sodium lactate. One millimol of sodium bicarbonate is 0.084 gm. One millimol of sodium lactate is contained in 1 cc. of molar sodium lactate; CO_2 is the serum CO_2 content in volumes per cent, and W is the body weight in kilograms.

If the plasma CO_2 is not known, Darrow[2] states that 5 millimols of $NaHCO_3$ (0.4 gm.) per kilogram of body weight is a safe dose in severe acidosis.

Sterile ampules of $NaHCO_3$ are now available and may be added to sterile water to make up a 1.3 per cent solution for intravenous administration. The sterile $NaHCO_3$ may also be added to the commonly used flasks of 5 per cent dextrose in water to make a 2 to 5 per cent $NaHCO_3$ concentration.[2]

Sodium Lactate: Provides sodium ions since the lactate radical is converted to glycogen, largely in the liver and burned for energy. Used for severe acidosis. A 1.75 per cent or one-sixth molar solution is isotonic. Molar sodium lactate solution is available in ampules. It is diluted to one-sixth molar concentration with distilled water or 0.9 per cent NaCl solution for parenteral use.

Hartmann[50] recommends a calculation of the dosage by the formula presented in the paragraphs on sodium bicarbonate, and using the one-sixth molar sodium lactate solution states that one-half should be given intravenously and one-half subcutaneously.

Sodium lactate should not be used in cases of severe liver damage[46] since it may then not be split and the sodium not become available for the treatment of the acidosis. Sodium bicarbonate is better in such instances.

SPECIFIC EXAMPLES OF WATER AND ELECTROLYTE LOSS

Important loss of water and electrolytes in surgical patients occur mainly by the abnormal loss of gastro-intestinal tract fluid, and vomiting or the continuous aspiration of fluid to prevent vomiting is the most common cause. Other serious water and electrolyte alterations occur with ketosis, with disturbances of kidney function in nephritis, and in burn patients. These situations will be discussed briefly.[3, 6, 9, 2, 15, 22]

In considering gastro-intestinal fluid losses the difference in the chemical pattern of the juices in different parts of the tract must be remembered because their loss produces different effects. Therefore, the concentration of the chief electrolytes in the important digestive fluids is shown in Table 4.

VOMITING FROM PYLORIC OBSTRUCTION

Vomitus, without achlorhydria, is predominantly acid and its loss results in a lowered plasma chloride value and a relative increase in plasma base as shown by an increased CO_2 combining power. Actually there is some loss of sodium but it is so much less than the loss of chlorides that the total base is relatively increased. In severe cases the picture is typically that of alkalosis, and while tetany from it is rare, dehydration is common. In infants the usual cause of such an obstruction is congenital hypertrophic pyloric stenosis while in adults the lesion is usually scar contraction from a long-standing duodenal ulcer or carcinoma of the stomach. Most workers agree that physiologic saline or Ringer's solution are quite suitable for the replacement therapy in the great majority of these cases. Only in severe alkalosis is HCl or NH_4Cl considered.

VOMITING FROM DUODENAL, JEJUNAL OR UPPER ILEAL LEVELS

The regurgitation of digestive fluid from these levels brings back a combination of saliva, gastric juice, bile, pancreatic juice and succus entericus. As shown in Table 4, some of

these fluids have more chloride ions than basic ions, while others have the reverse. The result is a loss of more nearly equal amounts of acid and base so that chemical studies on such patients usually show a definitely lowered plasma chloride value and a variable CO_2 combining power, generally not far from normal. The latter test, because it is relative to the strong acids such as chloride at the time of the test, indicates a definitely lowered serum base. If serum sodium studies are made they will be found definitely below normal. In these cases physiological saline or Ringer's solution is a suitable replacement fluid.

BILE OR PANCREATIC FISTULA DRAINAGE

Drainage of the common bile duct is a frequent surgical procedure which often results in a daily loss of from 500 to 2000 cc. of bile. As can be seen from Table 4 the base concentration of bile is greater than the chloride and as a result an inorganic acidosis can develop. Pancreatic fluid has a somewhat similar acid-base pattern and its loss will produce the same result. In serious dehydration from these causes the plasma chlorides are usually only moderately reduced while the CO_2 combining power or serum sodium may be lowered to acidotic levels. Corrective fluid can be physiological saline or Ringer's solution, but one of the so-called balanced solutions such as lactate-Ringer's solution is better because it provides the needed excess of sodium.

ILEOSTOMY DRAINAGE AND DIARRHEA

The effect of the loss of this material is about the same as the loss of bile or pancreatic juice. In each instance the sodium loss is greater than the chloride loss so that with copious excretion close attention must be paid to the electrolytes or a severe inorganic acidosis will develop. The plasma chlorides will be slightly or moderately lowered while the CO_2 combining power or serum sodium will be well down. Some of these patients, particularly the adult ones with more chronic illness, can eat and can thus take sodium bicarbonate and sodium chloride tablets by mouth. Thus it is not always necessary to give electrolytes parenterally to maintain normal levels in such patients.

Severe diarrhea, dysentery or copious ileostomy drainage have been associated with extreme extracellular fluid depletion and shock.[51, 52] One so commonly associates shock with blood loss that it is somewhat of a surprise to see extreme malaise, apathy, stupor, and shock with very low blood pressures respond promptly to the administration of an electrolyte solution. It is an example again of the proper replacement principle, that is, of giving the patient as nearly as possible what he has lost.

The best replacement solution if parenteral administration is necessary in cases of ileostomy drainage or diarrhea is lactate-Ringer's solution, since it provides the needed excess of sodium. Some still use physiologic solution of sodium chloride, and in instances of extreme acidosis sodium bicarbonate is added to it. The addition of potassium chloride is discussed later.

KETOSIS OF DIABETIC AND NONDIABETIC ORIGIN

In diabetes,[1, 2, 3, 22] an organic acidosis or ketosis may develop from a lowering of carbohydrate metabolism to the point where incompletely oxidized fatty acids begin to appear in extracellular fluid. Also, in many other disease conditions a partial or complete starvation may reduce carbohydrate metabolism to the point of ketosis. The kidneys respond by excreting the ketone acids in the form of their ammonium and sodium salt. With severe loss of the latter severe dehydration occurs, and as a sequel there is some loss of renal control permitting the abnormal retention of SO_4 and HPO_4 acid radicals and the inability to hold sodium chloride. A further depletion of electrolytes may occur from the vomiting so commonly associated with ketone producing diseases.

Treatment requirements are met by large amounts of lactate-Ringer's solution. If physiological saline solution is used an excess of sodium is often given by the addition of sodium bicarbonate or sodium lactate. The intravenous administration of dextrose solutions are also needed to overcome ketosis, with the addition of insulin if it is of diabetic origin.

NEPHRITIS

In severe acute and chronic nephritis[1, 2, 3, 22] the development of an acidosis is not uncommon. Altered kidney function may result in a retention of SO_4 and HPO_4 acid radicals and at the same time a loss of Na and C1 ions occurs from a failure to reabsorb them from the glomerular filtrate back to the plasma. A further serious disturbance in severe nephritis is a diminution or loss of ammonia formation in the kidneys. This process ordinarily allows the excretion of abnormal acids as their ammonium salt and thus spares sodium, but it fails sometimes in nephritis. Thus, dehydration with deficiency of extra-cellular electrolytes of an acidotic pattern is not uncommon. Darrow[2] states that although the patients may be edematous the serum concentrations of sodium are usually low, and small amounts of interstitial salt solutions* intravenously or of NaC1 and $NaHCO_3$ by mouth, enough to replace the urinary loss, are often beneficial to increase the diuretic effect of the good supply of water also given.

Lower nephron nephrosis is a relatively new disease in the consideration of acute renal insuf-

ficiency[70] and the reader is referred to Coller's, et al.,[71] recent discussion of its treatment. The latest experience with peritoneal irrigation for acute renal failure was presented by Frank, Seligman and Fine.[72] The use of gastric irrigation for the same purpose was recently discussed by Ormond and Klinger.[73]

BURNS

For twenty-four to thirty-six hours after burns[53, 54, 55, 56] there is an outpouring of plasma into the skin and subcutaneous tissue of the burned area that causes a decrease in circulating plasma volume and a hemoconcentration roughly proportional to the depth and extent of the burn. Electrolytes as part of the plasma fluid are trapped in the burned area and their concentration in the circulating plasma is mildly to very moderately decreased. With no actual loss of electrolytes from the body at the time of the burn Maddock and Coller[27] considered that very moderate amounts of electrolyte solutions intravenously should be given to burned patients, because with their usual marked acute hypoproteinemia salt solution further reduced the plasma protein concentration and produced edema. Darrow,[2] however, thought that physiologic solution of sodium chloride, interstitial salt solution* or lactate-Ringer's solution should be given in maximum amounts in extensive burns.

Interest was renewed in electrolyte administration to burn patients by Rosenthal's[57] work showing a lowering of the 48-hour mortality of scalded mice if isotonic sodium chloride was given orally within one hour following the burn. Sodium acetate, succinate, bicarbonate, and lactate were as effective as NaCl. Intravenous administration was less effective.

Potassium chloride increased the death rate, and when administered with NaCl antagonized the effects of the latter. Fox[58] then gave from 7 to 10 liters (10 to 15 per cent of body weight) of chilled isotonic (one sixth molar or 1.75 per cent) sodium lactate solution by mouth to a series of 23 burned patients with only 1 death, but considered a further evaluation of the treatment was needed. Moyer, Coller, et al.,[59] studying severely scalded dogs found that massive transfusions of defibrinated blood and large amounts of saline-bicarbonate solution by stomach was the only form of therapy employed that prevented shock without inducing complications that were incompatible with life.

In the resumé of fluid and nutritional therapy of burns by a committee of the National Research Council,[60] comments on electrolyte solutions for the prevention and treatment of burn shock, in the first 48 hours, were as follows: Burns of less than 10 per cent of the body surface: give 2000 cc. of physiologic electrolyte solution* each 24 hours, preferably by mouth; if not, by vein. For burns of more than 10 per cent of the body surface: chief reliance should be placed on plasma or albumin or whole blood as indicated. Orally give 3000 to 8000 cc. of physiological electrolyte solution* the first day, depending on the extent of the burn, and 3000 cc. the second day.

These pertinent comments give some of the present thought on the controversial subject of the use of electrolyte solution in the early treatment of burn patients, and the literature should be watched for further developments along these lines. All observers caution against too much salt solution after the first 48 hours.

RENAL INSUFFICIENCY WITH DEHYDRATION

There are many profound disturbances that occur during and immediately following severe dehydration. Insufficient kidney function is one of them and in most instances is due to a number of factors.

In severe dehydration there is a marked reduction in blood plasma volume which is accompanied by a lowered blood pressure and consequently a lowered filtration pressure through the kidneys. At the same time an increase in the osmotic pressure and in the viscosity of the blood plays an important additional part in greatly reducing the volume flow of blood through the kidneys as well as other organs.[61, 62, 63]

A further kidney factor is that of actual disease in the kidneys altering renal controls. This disease may have been previously present as a chronic nephritis, or it may have come on as a disturbance of function secondary to severe degrees of dehydration. Gamble[3] presents the possible alterations in renal controls as "retentions" due to inability to excrete substances like sulfates (SO_4), phosphates (HPO_4), and organic acid radicals, and secondly, the opposite errors of control in the way of "inability to reabsorb." He points out that plasma values are not established by a direct removal of surplus but by reabsorption of what is needed from tubular fluid. With permanent or temporary impairment of renal function, sodium in particular and chloride ions to a lesser extent may thus be lost through the kidneys even though they are needed to keep up normal concentration in the plasma.

A third factor in renal insufficiency in relation to dehydration is lack of water, and this properly has been emphasized for years. The kidneys use water to excrete body waste materials in solution. With insufficient water intake by mouth

* Interstitial salt solution is made up of NaCl 6.5 gm., $NaHCO_3$ 2.5 gm., KCl 0.18 gm. per liter. It is not on the market at the present time, but lactate-Ringer's solution can be substituted.

* Term physiologic electrolyte solution indicates a mixture of 2 parts of 0.9 per cent NaCl solution with 1 part of 1.3 per cent $NaHCO_3$ solution. If $NaHCO_3$ is not available 1.75 per cent sodium lactate solution may be substituted. These concentrations are approximately istonic.

the value of the parenteral administration of dextrose solutions in water cannot be too highly stressed. They provide easily available water to be spent as needed, the carbohydrate furnishes food for energy and reduces protein loss, and the maximum of this latter effect is gained by supplying 100 gm. daily for an adult.[3] Furthermore, the metabolism of this dextrose prevents ketone acid formation and relieves the kidneys of having to excrete these abnormal products at a time of many other stresses. A great deal is thus gained by providing a good intake of water and dextrose.

THE DAILY REPLACEMENT OF GASTRO-INTESTINAL FLUID LOSS

Modern medical practice in hospitals requires that dehydration not be allowed to develop in patients. If gastro-intestinal fluid losses are occurring, daily replacement of the water and electrolytes are essential. By means of collecting bottle apparatus and proper house staff and nursing care the daily drainage is collected and measured. Common sources of such drainage are from aspiration of gastro-intestinal fluid through Wangensteen or Miller-Abbott tubes or one of their modifications, or from biliary tract drainage. Less common sources are pancreatic and intestinal fistula drainage and from ileostomies.

The concentration of the important electrolytes in these secretions and in some of the replacement solutions is shown in Table 4. There is some variation in the electrolyte pattern of any given gastro-intestinal juice, particularly in vomitus, and there largely dependent upon the acid production and the amount of fluids taken shortly before the vomiting. The greater acid nature of fundus gastric juice over that of pylorus gastric juice is shown. Unless there is an achlorhydria, vomitus carries away much more chlorides than sodium. From there on down the sodium loss is greater than the chloride loss with the difference being most marked in low ileal and colon secretion.

Table 4 shows importantly that the concentration of the electrolytes in physiological saline or Ringer's solution is approximately equal to or greater than their concentration in the digestive fluids. It was therefore suggested in 1937[64, 65] that volume-for-volume replacement of a digestive fluid loss with physiological saline or Ringer's solution would maintain sodium and chloride electrolyte concentrations at nearly normal levels. Subsequent studies by Coller, et al.,[26, 34] have found this approximation to work quite satisfactorily. When continuous gastro-intestinal suction is started it is well to give a liter of physiological saline or Ringer's solution on the first day of the suction in order to forestall an appreciable initial drop in electrolytes. If it is apparent that the immediate suction drainage loss is very large, then more than a liter of these solutions should be given the first day. From then on, volume-for-volume replacement works well.

For biliary tract drainage, which carries away more sodium than chloride ions, lactate-Ringer's solution can be used for replacement on the volume-for-volume basis.

Hoffman[66] recently supported the use of the volume-for-volume replacement method, and Moyer[18] employs it but gives an 0.45 to 0.6 per cent sodium chloride solution instead of the physiological saline solution.

A different way of calculating daily replacement of lost electrolytes comes from the pointed out fact that the sodium chloride concentration of the gastro-intestinal tract fluids, calculated from the chloride concentration, is about 5 gm. per liter.[64] Wangensteen[10] employs this principle by giving 5 gm. of salt in the form of physiological saline solution for each liter of fluid aspirated by continuous gastro-intestinal suction.

These approximates for the daily replacement of gastro-intestinal fluid loss work quite well for the average case, but special care is necessary when the amount of fluid abnormally drained from the gastro-intestinal tract is large, more than 2000 cc., for several days. Then, along with the volume-for-volume replacement rule frequent blood chemical studies should be made as checks, and alkalosis or acidosis looked for.

Table 4

	Meq./L.			NaCl in gm./L.	
	Na.	Cl.	HCO_3	Rge.	Av.
Fundus gastric juice (70)	27	158			
Pylorus gastric juice (70)	157	142			
Total gastric juice (3)	22	145			
Vomitus (64)	3-78	20-106		1.2-5.5	
Vomitus (26)				1.2-6.2	3.3
Duodenum (70)	165	118			
Gastroduodenal drainage (26)				1.9-7.9	5.7
Hepatic duct bile (3)	142	108	40		
Hepatic duct bile (64)	147	130			
Hepatic duct bile (26)				3.5-6.4	5.1
Pancreatic juice (70)	157	115	43		
Pancreatic juice (3)	145	38	113		
Jejunal secretion (3)	141	115	32		
Enterostomy drainage (64)	95-106	74-103			
Intestinal fistula drainage (26)				3.0-8.8	5.2
Ileal secretion (70)	155	81	90		
Colon secretion (70)	153	83	91		
Diarrheal stool (26)				3.7-5.2	4.3
— — —					
Physiological saline solution	155	155			9.0
Ringer's solution	148	158			8.6
	(K 4)			(KCl 0.3)	
	(Ca 6)			($CaCl_2$ 0.33)	
Lactate-Ringer's	125	111	(Na-Lac 2.5)		6.0
	(K 4)			(KCl 0.3)	
	(CA 4)			($CaCl_2$ 0.2)	

Table 4. THE CONCENTRATION OF ELECTROLYTES IN SOME DIGESTIVE FLUIDS AND IN COMMONLY USED RESTORATIVE SOLUTIONS

POTASSIUM

A renewed interest in the subject of potassium has resulted from the work of Govan and Darrow[24] who in 1946 reported a reduction in the

mortality of infants with diarrhea from 17 in 53 to 3 out of 50 by treating their dehydration with a solution containing potassium chloride in addition to sodium chloride, sodium lactate and glucose. This striking result is a further example of the long line of outstanding pioneer work done by pediatricians on water and electrolyte problems, and the surgeons and others interested in such problems owe much to their basic studies. The surgeons are more concerned with the abnormal loss of fluid from the upper and of the gastro-intestinal tract, but they also are confronted with severe dehydration probably involving important losses of potassium.

In an article on severe dehydration due to diarrhea Darrow[67] has reviewed important concepts on potassium as follows: The knowledge of the loss of potassium as well as sodium and chloride in severe diarrhea is not new. An extensive disintegration of cells has long been to occur and the loss of potassium was found to be relatively greater than the loss of nitrogen. Holt, et al.,[68] in discussing replacement of this loss said that not only water and sodium are needed, but also potassium and magnesium, and that a better solution could be devised than physiological saline or Ringer's solution. However, over many years adequate amounts of potassium were not given, probably because of two reasons: 1. the realization that a rise in the concentration of plasma potassium could produce death by stopping the heart, and 2. cellular membranes were considered to be relatively impermeable to cations and hence loss of potassium was considered to be caused by some fundamental change within the cells. The latter proposition is no longer tenable, since in the past ten years it has been shown that intracellular fluid contains some sodium, and potassium readily crosses the cellular membranes. Intravenous potassium can produce heart block when serum concentrations reach a level of 10 to 12 mM per liter,[69] but if the dosage is given slowly and the total amount is not too high this complication can be avoided. The kidneys can excrete potassium in concentrations of over 100 mM per liter so that a good output of urine is an added safeguard against a dangerously high potassium concentration.

The concentration of electrolytes used by Darrow[67] in the treatment of severe dehydration produced by diarrhea in infants is potassium chloride 2 gm., sodium chloride 3 gm., 1/6 molar sodium lactate solution 250 cc., and water 500 cc. About 80 cc. of such a solution per kilogram of body weight are given to the infants over a period of four to eight hours.

Potassium is therefore a substance to be thought of when large electrolyte replacements are needed, but considering the complications of heart block and erythema with desquamation, Darrow's[24] article should be reviewed before potassium is given.

FINAL COMMENT

The administration of intravenous fluids is not too trying to the patients, particularly if the initial puncture is done skillfully. No one likes to be jabbed several times. The needle in place is not uncomfortable but being tied down in one position is, so every effort should be made to select a flat area where the needle can be taped down and the arm and body moved about at will. The arm veins are preferable to the leg veins because thrombophlebitis is more common in the latter and much more serious.

Intravenous fluids should be administered during the day if possible, and the night left free for sleep. This requires vigil by the house staff to start the fluids early in the morning, before going to the operating room.

A satisfactory general rate for intravenous fluid administration for volumes up to 3500 cc. daily in 350 cc. per hour. For special reasons such as older, debilitated or the most seriously ill patients lower rates are desirable. Larger volumes also should be spread over a 24-hour period.

It is disconcerting to have an unsatisfactory urine output because the patient did not receive the amount of fluid ordered. Many factors, such as the needle coming out of the vein, the fluid running into the tissues, or the hourly rate not being controlled well enough may be the reason given, but the deficiency can be very harmful to the seriously ill patient. A good plan of therapy can thus fail through its poor execution and a smart resident seldom lets such things happen.

Because of shying away from the old tendency of over-salting patients with its resulting edema formation, there occasionally occurs the reverse error of not giving sufficient electrolytes. Constant attention is needed to avoid both mistakes.

Considerable material is given in this paper and an effort has been made to write it in a practical and usable form. This is not always easy because some water and electrolyte problems are complicated and require highly technical discussions. The majority of cases, however, are relatively simple and should be presented in a manner understandable to the physician and thus of aid to him in the care of his patients.

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Rupture of Appendiceal Stump Three Months After Uneventful Appendectomy With Repair and Recovery

LUTHER O. BAUMGARDNER, M. D.

RUPTURE of the cecum at the site of the appendiceal stump following appendectomy is a rare occurrence. Babcock[1] mentions it as occurring between the fifth and fourteenth day after operation due to a large enema. Saurez reported a case of cecal necrosis following appendectomy. Alves[2] reported two cases of cecal rupture after appendectomy with closure. Vianna[3] reported a case of general peritonitis after ligature and invagination of the appendiceal stump. Spivak and Busch report a case of phlegmonous cecitis. Prima[4] mentions the association of appendicitis with necrosis of the cecum.

This patient, in the case reported in this paper, was operated on for acute appendicitis and made an uneventful recovery. Three months after operation while at work cecal rupture at the site of the appendiceal stump occurred. He was operated on again, the rupture closed; and recovered.

CASE REPORT

M. W., colored male, aged 55, was first examined at his home at 5:05 p. m., October 11, 1942. He complained of pain in the lower right quadrant of his abdomen. The pain had started the previous day and was generalized abdominal in character. The pain was followed by vomiting. There was tenderness at McBurney's point, and muscular spasm was present in the lower right quadrant of the abdomen. Temperature was 99 F., pulse rate 83. A diagnosis of acute appendicitis was made. He was admitted to Mount Sinai Hospital.

Laboratory Findings: White blood count, 15,000 per cmm; hemoglobin 80 per cent. Urine: Specific gravity, 1013; albumin—, sugar—, acetone 0. Red blood cells, 2 to 10 per high power field.

Operation: October 11, 1942, 11:30 p. m. Spinal anesthesia was used, 1505 mg. novocain in third lumbar interspace. The abdomen was opened through a right McBurney incision. The appendix was gangrenous proximally and some of the omentum was around it. The meso-appendix was thickened and friable. The appendix was removed with the cautery after ligating the meso-appendix and freeing the appendix. The stump of the appendix was ligated with No. 1 chromic catgut. The stump was not invaginated. The cecum was indurated and not suitable for holding sutures. Sulfathiazole powder, 5 gms., was placed in the abdomen and 3 grams were placed in the abdominal incision after closing the peritoneum. The incision was closed in layers without drainage.

Recovery was uneventful. The patient was discharged from the hospital on October 23, 1942, with the incision healed and no complaints. He was examined at my office on November 1, 1942. His condition was good and he was discharged from observation.

Pathologic Report: (Dr. A. M. Young and Dr. F. Preuss) Final Diagnosis: Acute suppurative and gangrenous appendicitis (marked) proximal third. Acute fibrinopurulent periappendicitis (considerable). Involution of appendix (distal end).

SECOND HOSPITAL ADMISSION

This colored male, aged 55, came to the emergency room at Mount Sinai Hospital at 2:00 a. m. on January 8, 1943. He complained of severe pain in the lower part of his abdomen. The pain had begun several hours earlier while he was at work as a night porter. He had been working regularly for about one month and had no complaints until seized with this acute abdominal pain. He attributed his pain to a raw onion he had eaten the same night. He was admitted to the hospital as an acute abdominal emergency.

When I examined him several hours later his pain had somewhat subsided, but there was marked tenderness in the lower right quadrant of the abdomen. Also, there was rebound tenderness. The signs and symtoms were those of acute appendicitis in a man whose appendix had been removed three months prior to this illness.

Laboratory Findings: White blood count, 11,800; red blood count, 4.79 million per cmm. hemoglobin, 13 grams per 100 cc.; blood sugar 105 mg. per 100 cc.; blood type III (Moss). Urine: Acid, specific gravity 1005. Albumin: —, Sugar — negative: white blood cells occasional.

His symtoms were definite and persistent. His general condition was good, so it was decided to explore the abdomen. The preoperative diagnosis was "Rupture of Appendiceal Stump."

Second Operation: January 8, 1943. Spinal anesthesia 150 mg. novocain in second lumbar interspace. The abdomen was opened through a right rectus incision. A moderate amount of seropurulent exudate was present when the peritoneal cavity was opened. The cecum was exposed. There was a linear rupture in the cecum at the site of

Submitted July 8, 1948.

The Author

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the previous appendectomy about 3 cm. in length. No part of the appendiceal stump was present.

The opening in the cecum was closed with three layers of fine silk interrupted sutures. Then several No. 1 plain catgut sutures were used to tack the cecum to the parietal peritoneum thus excluding the suture line in the cecum from the general peritoneal cavity. Sulfanilamide crystals (10 grams) were placed in the peritoneal cavity and 4 grams of the same were placed in the abdominal incision after closing the peritoneum. The abdominal incision was closed without drainage.

Postoperatively he was put on a peritonitis regimen with nothing by mouth, and Wangensteen suction. He was given 1000 cc. 5 per cent glucose in normal saline and 2000 cc. 5 per cent glucose in distilled water intravenously daily until January 12. Also 100 mg. vitamin C and 20 mg. thiamine were given parenterally daily for seven days. Wangensteen suction was discontinued on January 12 and mouth feeding was started. He ate well as soon as he was allowed food by mouth.

A blood transfusion was started on January 11, but had to be discontinued because chills and a rise of temperature (102 F.) developed.

Laboratory Findings:

		January 9, 1943 Milligrams per 100 cc.	January 11, 1943 Milligrams per 100 cc.
Blood:	Sugar	105	135
	Creatinine	1.5	1.6
	Sodium Chloride	586	532
	Sulfonamides	1.8	Less than 1 mg.
	Total Proteins		7.2
	Albumin		4.8
	Globulin		2.4

Recovery was uninterrupted. The patient was discharged in good condition from the hospital on January 20, 1943.

He has remained well and has had no further illness attributable to his appendix at the time of this report.

COMMENT

Speculation arises as to the cause of the appendiceal stump rupture and also as to why the long interval of three months after appendectomy before the rupture. Also it is difficult to explain the absence of symptoms in the interval prior to the rupture.

Much has been written on the best way to treat the appendiceal stump following appendectomy.[5, 6] Localized abscess[7] at the site of appendectomy has been shown to occur in some cases in which the stump is ligated and buried with a purse string suture. In such cases the abscess usually discharges into the lumen of the cecum. It may pursue a less favorable course and discharge into the peritoneal cavity. In the case here reported the appendiceal stump was ligated and not buried.

Another possibility suggests itself. That is, whether the local use of sulfonamides in the peritoneal cavity delays healing of the appendiceal stump or intestinal wounds. I have observed delayed or non-healing of skin wounds following the use of sulfonamides in skin incisions. In such cases the skin edges fall apart with no evidence of healing when the skin sutures are removed seven to nine days postoperatively even though no infection is present.

The good result in this case was due to prompt recognition of and operation for an acute abdominal emergency. The earlier the operation the better the prognosis in cases of ruptured viscus. This is well illustrated in the management of perforated peptic ulcer.

The good results from the use of sulfonamides can be obtained better and with greater safety by parenteral and oral administration. Attention to the fluid and electrolyte balance and gastro-intestinal suction serve to make surgical convalescence smoother and more certain.

SUMMARY AND CONCLUSIONS

1. A case of appendiceal stump rupture occurring three months after an uneventful appendectomy is reported. The patient was well and had no complaints between the time he left the hospital and the rupture of the stump. The rupture was recognized and repaired and the patient has remained well.

2. The question is raised as to whether the local use of sulfonamide in the peritoneal cavity has any effect on healing of intestinal wounds.

3. Prompt recognition of an acute surgical emergency and immediate operation were the main factors in the successful management of this case.

4. Modern surgical postoperative treatment such as proper intravenous fluids and gastric suction made the convalescence smoother and more certain.

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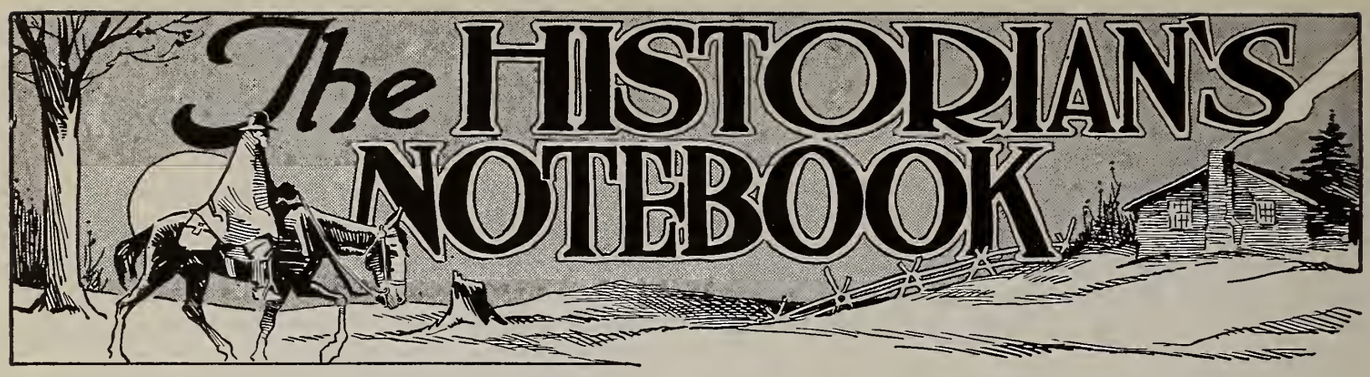
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Gastric Diverticulum

Indications for surgery in cases of gastric diverticulum appear to be poorly understood by the profession generally. It is true that a high percentage of gastric diverticula are symptomatic. It is also true that medical management with antispasmodics, bland diet and postural drainage will suffice to relieve the symptoms attributable to certain diverticula.—R. S. Smith, M. D., and J. D. Mortensen, M. D., Boise, Idaho; Northwest Medicine, Vol. 48, No. 3, March, 1949.



Medicine 100 Years Ago: As Revealed By a Student's Notebook

Reported by LeROY L. BELT, M. D., Lacarne, Ohio

A NUMBER of years ago a lady came to my office and wanted to know if I desired some old medical books. They had been the property of Dr. William Andrews who died years ago. I have had no time to look at them until a short time ago when I left active practice. Most of the books were of no value to me so I sent them along with the rest of my library to the Cleveland Medical Library. This one notebook looked interesting so I kept it and now have had time to go over it. I thought it might be interesting to relay some of the notes to show the difference of treatment, thinking, and actual expressions used just 100 years ago. I have not dared to change or alter the spelling or punctuation in any way. It is more interesting and human in the original.

CASE BOOK. COMMERCIAL HOSPITAL CLINIC

Notes taken while at Cincinnatti during the winter of 1849-50. Medical College of Ohio, Hospital—Clinic, etc.

Nov. 6, 1849: Prof. Mussey treats the slow poisoning of Lead by administering 1 draghm by measure of Strong Sulphuric Acid dissolved in one pint of distilled water per diem. At the same time keeping the bowels soluble by occasionally giving active cathartic pills, composed of Colocynth, Croton Oil, etc., to be followed in the morning by 01. Ricini one ounce, Lenbinth one ounce. He says in most all strongly marked cases of Lead Poisoning there is a blue streak running around on the gums and sometimes extending to the edge of the tongue. Two cases were brought from the "Wards" illustrating the above.

(Some time later)

The case of lead poisoning mentioned in Case 1 was again introduced. There has been some improvement. He can now walk a little and can move his arms a little. He has taken the dilute Sulphuric Acid as first prescribed for some two weeks. It was now ordered to be discontinued for a short time. The lead lines on the gums are gradually disappearing. The patient is a good deal emaciated.

JOHN G. WITTMAN—AGE 29—BUTCHER BY TRADE

Complained four weeks ago of pain in the chest. For the last three weeks there has been slight diarrhea. The extremities are now edematous and pit from pressure; pulse 100. Skin sallow with general infiltration over the surface. Tongue red at tip and edges with coat over the surface. There are spots of extravasated blood on the lower extremities resembling Purpura Hemorrhagica or Scurvey. Diagnosis—not able to make out, suppose, however, that it is Dropsy. He has been taking Calomel 2 gr., Squills 2 gr., every 4 hours for two days. Treatment continued with the addition of Nitrate Potassa 6 gr. to each dose.

(Five days later.)

In this case absorption has taken place to some extent under the influence of the treatment instituted. The Calomel has been omitted and he is to continue taking Squills 2 gr., Nitrate Potassa 6 gr. His general aspect today is pretty good. Bowels have moved about once in every 3½ hours (too often). Discharges yellow and thin.

* * *

MR. NOSMAN—AGE 19—BLACKSMITH

Had intermittent fever 3 months ago in St. Louis which continued 3 weeks. His countenance is pale and looks like a man who had the chills and enlarged spleen. He now complains of dizziness of the head and hardness of hearing. Pulse 120-tongue furred. There is dullness of percussion over the left hypochondriac region owing to the enlarged spleen. Prof. Drake thinks there is some hypertrophy of heart as indicated by the violent pulsations of that organ against the chest, in addition to his pallid features. No prescription made in reference to the latter ailment. For several days he has been kept on 2 gr. each of Extract Rhei and Mass. for the purpose of correcting the morbid secretions. In addition to the foregoing he is now directed

to take 5 gr. of Hidigidate of Potas. 3 times per diem the object of which is to reduce the enlarged spleen.

* * *

MR. ARMSTRONG—AGE 45—WOODCHOPPER

Has had jaundice and chills together and alternately. He now has Ascites with a little edema of the ankles on the inside. Right and left being very dull on percussion behind and below each nipple—has cough—spleen enlarged with ampic tendency. Prof. Drake thinks the dropsy is the sequelae of diseased liver. Pulse languid and empty from the rapid drain of serum from the circulating fluid. Prognosis unfavorable.

Prescrip.—Has been taking calomel, ipecac, squills and nitre—purged with calomel and jalap. Ordered now—Nitrate pot. 1 dr., elaterium 1 gr. divided into six parts—dose one every hour until hydrogogue catharsis is produced.

(Five days later.)

Patient no better. The Elaterium and Potass. would not lay on the stomach. Calomel and squills was substituted. There has been a large discharge of blood today from the bowels which Prof. Drake regards as unfavorable, being looked upon as hemorrhage following disease of liver and spleen. Prognosis still unfavorable.

Prescription—Nitrate Potass. 2 dr., tr. digitalis 2 dr., dr. Opii 2 dr, *(cannot read)* oz. 8. Dose—1 oz. to be taken every two hours.

(Two days later.)

His urine was examined by Prof. Drake in the presence of the class by suspending some of it in a small glass tube over the blaze of a spirit lamp until it boiled. (The crystal of a watch will answer the same purpose.) The object is to ascertain if it contained albumin, which would have coagulated. Nitric acid was also added for the same purpose. As no albumin was present it was concluded that the effusion did not depend upon an inflammatory condition of the organs.

The general aspect of the patient today is much the same. Abdomen a little more distended —pulse 100—small in volume and feeble in force. Dullness on percussion on both sides of chest indicating accumulation there also. The Prof. took occasion here to remark that Hydroptic accumulations in the chest sometimes occasioned sudden death by the lung or lungs being compressed by the water from a change of position of the patient producing suffocation.

As the treatment so far has proved fruitless and the patient sinking, the propriety of Paracentesis Abdominus was taken into consideration and resolved upon in a few days if there was no amendment. Treatment continued with little variation.

(Three days later.)

The dropsy case expired wtih symptoms indicating pressure of lungs by collection of serum. His urine was analyzed by Dr. Raymond and found to contain a large amount of Lithic Acid. In the postmortem which was made his liver was found to be a good deal indurated which induration caused the ascites by mechanically obstructing the circulation through that organ, thereby affecting the circulation through the mesenteric arteries producing effusion in the cavity of the peritoneum.

CASE OF ORCHITIS (SWELLING OF THE TESTICLE)

This was an acute case. The organ was very much swollen and painful with great redness. Leaching and water dressing was ordered with the necessary constitutional treatment. After the acute stage has been subdued and all the pain pretty much overcome the case will be treated by compression with adhesive strips.

* * *

NOVEMBER 15. CHRISTIAN MACKINTOSH—TYPHOID FEVER

This is the first time we have seen this patient. He has been sick some time, however. He has been kept on Wine Ipecac and sulph.—Morphia. His general appearance to-day is dull bearing the marks sure enough of Typhoid Fever. Pulse 108—tongue red and thickened at the edges. Skin somewhat relaxed. There are remains of petechia on the surface. Prescrip. Vinous Ipecac 1 dr., Morphia gr. 1/100 to be given every 3 or 4 hrs.

Nov. 17. Some improvement in his condition. The expression is better. General aspect not so dull and is entirely rational (which he was not before—a symptom not noted). The tongue is moist on the edges but somewhat dry in the center, but little sordes about the teeth. Bowel complaint also stopped but skin was harsh and dry. He was ordered to take now 1 oz. Spiritus Mindererus in addition to the above prescription every 3 hrs.

Nov. 18. Not so well to-day. Countenance dull with a lusterless eye. Pulse 100 feeble and thready. Extremities cold and shriveled—night mutterings. Petechia showing itself again on the surface. Bowels moved 3 to 4 times per hour. Prognosis unfavorable. His feet were ordered to be put out over the edge of the bed and immersed in a stimulating pediluria and rubbed thoroughly. The period having passed for the administration of ipecac and morphine. Wine whey in connection with gum camph. 4 gr. the latter to be taken once 4 hrs.

Nov. 24. General appearance much the same. Three watery discharges during the night. Tongue moist but red and pointed—pulse 130 and very feeble with great emaciation. Temperature of surface natural. Ordered Carb. Amm. and wine with as much nourishment as he will bear.

Nov. 26. This patient expired yesterday and on postmortem more or less redness was found on the surface of the stomach with thickening and softening. The Isolated or Brunners glands slightly exagerated. Jejunum entirely healthy. Peyers glands were all in a state of ulceration. Some of the patches were ulcerated through to the muscular membrane and in one patch the ulceration had extended through to the serous coat. Between one of the folds the intestine had also adhered. The inflammation in the intestine was confined principally to the lower three feet of Illium. Spleen somewhat enlarged and softened. Liver enlarged and presented somewhat the nutmeg appearance. The mesenteric glands in the neighborhood of the diseased Peyer's Glands were somewhat enlarged as is always the case. Heart much reduced in size and flabby in consequence of the gradual diminution in the force of the circulation, the heart accommodating its cavities to the diminished

quantity of blood poured into it. Lungs healthy except the existence of hypostatic pneumonia from laying so long a time on his back.

It seems strange that when pressure was made over the abdomen this patient evinced no pain, nor complained of any tenderness notwithstanding the extensive disease that existed within.

Prof. Lawson here stated briefly the differences between Typhoid and Typhus fever. The former is always more or less accompanied with muttering delerium especially at night, picking at bed clothes and always attended with disease more or less in Peyer's Glands. While in Typhus Fever there is a slow continued grade of fever without these lesions. He stated some other points of difference now forgotten.

* * *

PUERPERAL FEVER—PROF. WRIGHT

This sometimes appears as an epidemic and carries off a great number of females, and no two epidemics are just alike, each one partaking more or less of the character of epidemics which may be prevailing at the time and particularly of erysipelas.

It most generally commences in from 24 hours to 3 or 4 days after delivery. There is pain in the hypogastric region, loins preceded by a chill resembling that of an intermittent—'tis not so severe as in ephemeral fever. It sometimes terminates fatally without any pain being manifested.

There is a tendency to watery discharges from the bowels which require opiates. There is also nausea and vomiting,—finally the coffee ground fluid is ejected, the abdomen is distended and tympanitic. The mind is composed and clear to the last period except when influenced by opiates.

* * *

CHAS. POWERS—DISEASE—CHOLERA, OCT. 29

This man was brought into the Hospital two or three days since in company with another patient laboring under the same disease, since dead, both Boatmen, just from New Orleans. He is now in a state of reaction having passed through the stage of collapse. Condition torpid with a very dull eye and inexpressive countenance. Eyes covered over with mucous and slight hyperemia of conjunctiva. Pulse 60 and sufficiently full. He is now in the condition in which many die from inflammation of the cranium. To obviate this result, revulsions were directed, the feet and legs to be put into stimulating Pediluvium and thoroughly rubbed; blisters to be applied on the inside of the ankles and to be cupped on back of neck; the hair to be cut off and tepid water freely applied. For the fullness and tension of the abdomen he was ordered Sub. Hydrarg 2 grs. Dum. Camph. 2 grs. rubbed down with Gum Arabic and loaf sugar to be given every 2 hours.

* * *

I could go on copying these cases for hours and every one of them would have an interesting sidelight on the thinking and expressions of our brothers of a short 100 years ago. The main thing that impresses me is the attention they stressed on the general appearance of the patient. Sometimes I fear that while we are much advanced in both diagnosis and treatment over those days, we sometimes do not take enough time to really look at our patients. There are a great many things we can find out by simply standing at the foot of the bed and getting a general picture of our problem before going at it scientifically.

This notebook must have been Dr. Andrews' bible of practice, because scattered through it are copies of new prescriptions as he heard them. Among the many things are formulas for black, blue, and red ink; prime vinegar; chemical soap; white wash; Elderberry wine; how to kill rats and roaches; Buggy Paint; amalgum for filling teeth; to whiten linens; curing hams; a superior glue; cleaning marble and cement; bed bug poison; tobacco flavoring. Toward the end of the book we find formulas for various types of cordial, upset stomachs, and then a "Recipe for Drunkenness" and lastly a "Prescription for Baldness."

Review of Books on History

An Account of the Weather and Diseases of South Carolina, by Lionel Chalmers, M. D., of Charles-Town, South Carolina, *(London, Printed for Edward and Charles Dilly, MDCCLXXVI)* is a facsimile from the original, issued through the kindness of Mead-Johnson as their part in the celebration of the Centennial of the South Carolina Medical Association. An introduction has been added by Joseph Ioor Waring, M. D., of Charleston, South Carolina. The selections have to do with problems of the sickness of children. Dr. Chalmers published in London in 1776, 446 pages in two volumes of *"An Account of the Weather and Diseases of South Carolina."* Of these, some 50 pages are devoted to subjects strictly pediatric and these pertinent pages have been lifted to make this delightful souvenir.

Aetiological Principle of Pyaemia in Ancient Egyptian Medicine, by Robert A. Steur, ($1.50. *The Johns Hopkins Press, Baltimore, Maryland)* is a comprehensive study of the Egyptian word whdw as expressing one of the basic concepts of Egyptian medicine.

Gentleman's Progress, The Itinerarium of Dr. Alexander Hamilton, 1744 ($4.00. *University of North Carolina Press, Chapel Hill, North Carolina)* has been republished for the Institute of Early American History and Culture. The work is one of the happiest combinations of liveliness, art and instructive information written in colonial America. It is the description of his journey from Anapolis, Maryland, to York, Maine, and return with a side trip up the Hudson to Schenectady.

Study of Child Health Services . . .

Ohio Pediatricians Submit Findings on the Nature of Medical Care Children of State Are Receiving, as Part of Nation-Wide Project

SECOND INSTALLMENT

Editor's Note:—On authorization of The Council, The Ohio State Medical Journal is publishing in installments a report covering a study of child health services and facilities in Ohio, made by Ohio pediatricians who are members of the American Academy of Pediatrics which has sponsored similar studies in many other states. The accompanying article is the second installment of the report. The report was compiled by those actively engaged in the study and any conclusions or findings appearing therein are those of the study committee.

CHAPTER II

TOTAL VOLUME OF CHILD HEALTH CARE

MEDICAL CARE

It is difficult to ascertain the exact amount of care needed by children. An estimate can be made only by comparison. The total volume of medical care received by children in Ohio on one day during the report year was obtained by adding together the medical care (expressed as visits or hospital days) rendered to children: (a) in private practice (office and home); (b) in clinics, outpatient departments, well-child conferences, mental hygiene clinics, and community health services for physically handicapped children; and (c) in hospitals. This sum represents the total number of children under medical care on one day, and, when related to child population, gives a useful index of total volume of medical care.

This quantitative measure of the total volume of medical care provides a means for comparing the amount of care children received in Ohio with that in other states and also enables one to contrast the quantity of care received in areas of the state, which differ in population, geographic locations, and socio-economic levels. These data do not necessarily show that children, living in areas where the greatest amount of care was reported, were actually receiving adequate care, either quantitatively or qualitatively. No standard has as yet been established to represent adequacy, but the better supplied areas do serve as a basis for comparison.

Quantitatively, medical care rendered to children in Ohio ranks seventeenth when compared to the other states of the nation and was better than the average. Figure 6 compares Ohio with the highest, average, and lowest of the states and with two neighboring states in respect to the three components of medical care: private practice; clinics; and hospitals.

Two broad county groupings have been used for comparison of total volume of medical care. Persons in counties classified as "adjacent" frequently obtain medical care in the adjoining metropolitan counties. (Figure 7)

The isolated semi-rural counties are grouped together with the isolated rural. In studying these two groups, it must be remembered, that where there are transportation facilities, many persons in the isolated counties have access to medical services in metropolitan areas of Ohio or of neighboring states.

The accompanying table shows the medical care received per thousand children per day in the two county groupings.

Number of Children Under Medical Care Per 1,000 Children Per Day

	Total Children	Visited by Physicians[a]	Visiting Clinics[b]	In General Hospitals[c]
Metropolitan-adjacent counties	14.8	11.5	.36	2.9
Isolated counties	13.6	11.8	.02	1.7

a. Office and home.

b. Exclusive of mental hygiene and physically handicapped clinics, and special hospitals.

c. Exclusive of special hospitals.

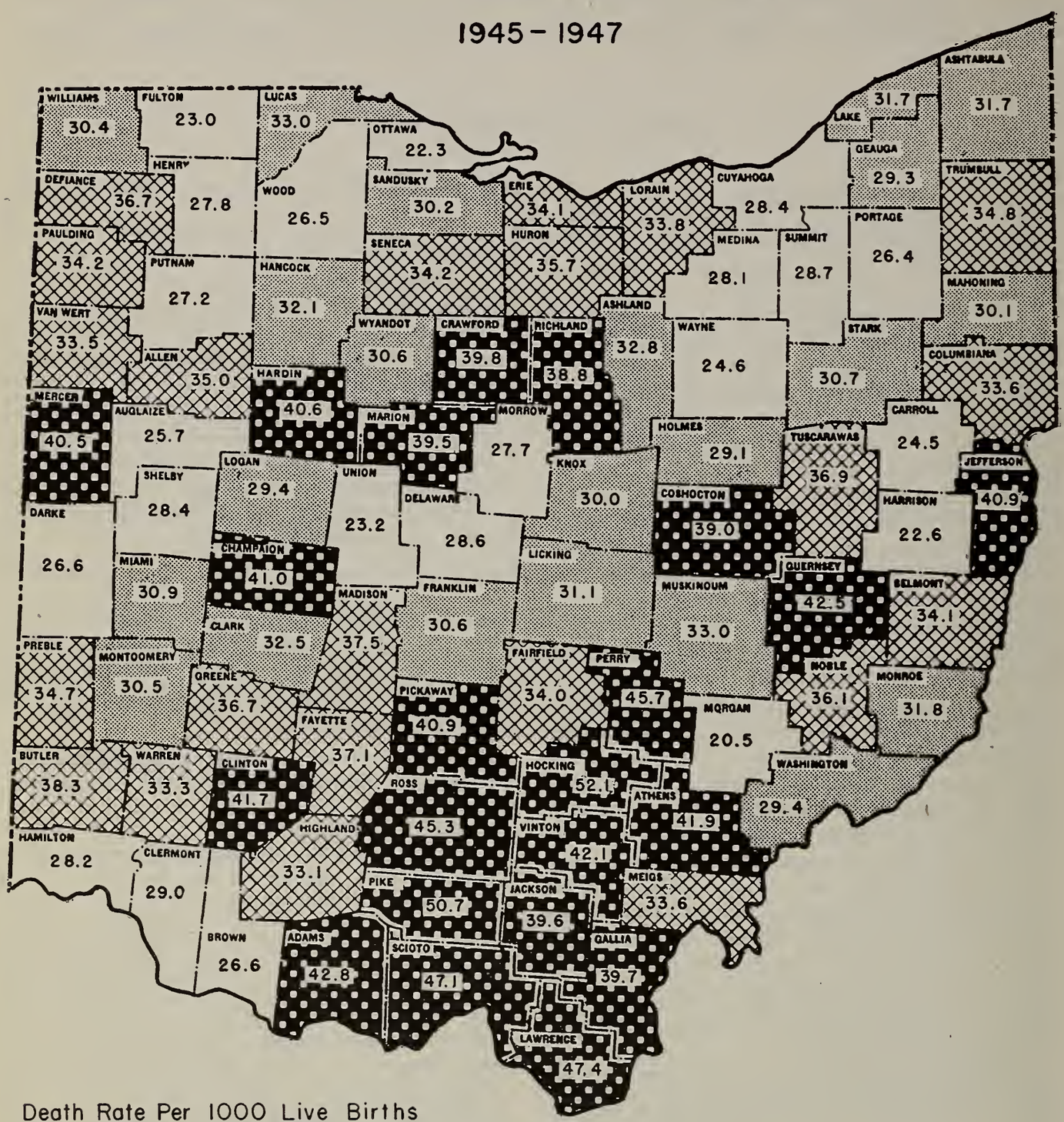
Children in the isolated counties in Ohio received about the same amount of care in private practice as those in metropolitan-adjacent counties, but they received much less care in clinics and hospitals.

Medical care includes care of sick and well children. Health supervision is composed of two elements: visits to child health conferences and to physicians' offices.[4] Of the total number of

Fig. 5 INFANT DEATH RATE PER 1000 LIVE BIRTHS

By County of Residence of Mother

1945 - 1947

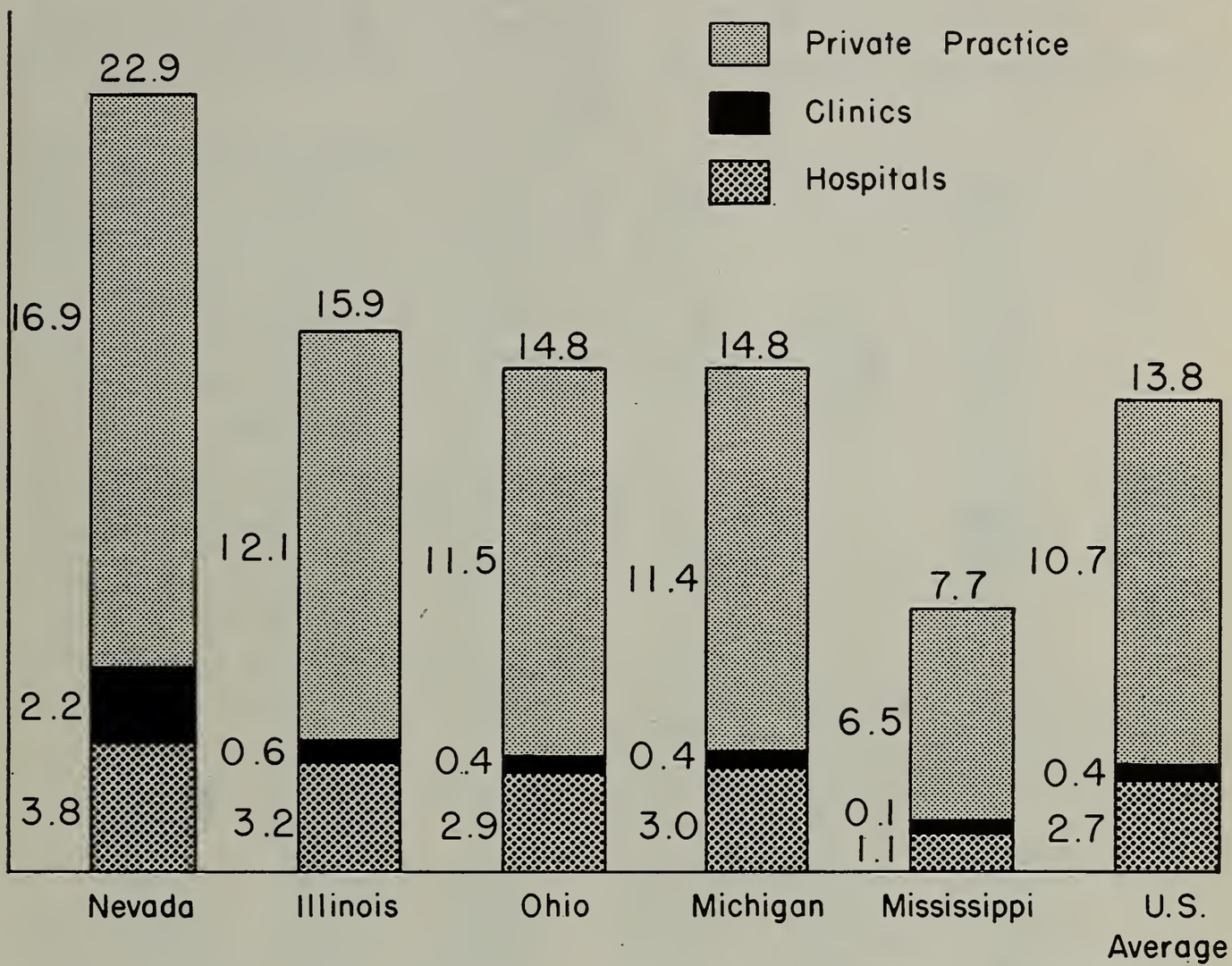


children under medical care (exclusive of newborn) about one-fourth (24.3 per cent) were under care for health supervision on an average day.[5]

DENTAL CARE

Compared to the rest of the United States, children in Ohio received more than the average amount of dental care; Ohio ranked sixteenth as

Fig. 6. Total Volumn of Medical care for Children on one day per 1000 Children in Ohio Compared with Selected States



to the number of children under dental care. Dental clinic service was 2 per cent of the total volume of dental care in Ohio. With respect to such service, the state was on a par with the average for the country. (Figure 8)

Children Under Dental Care Per 1,000 Children on One Day

	Total Children	Private Practice	Dental Clinics
Ohio	3.5	3.4	0.1
Highest (Mass.)	7.2	6.5	0.7
Average	3.3	3.2	0.1
Lowest (N. Mex).	0.9	0.9	less than 0.05

The number of children under dental care on one day in the metropolitan-adjacent counties was 3.7 per 1,000 children as against 2.2 in the isolated counties. The rate for dental clinics was 0.08 per 1,000 children in metropolitan-adjacent and 0.006 in isolated counties.

SUMMARY

1. Ohio was quantitatively somewhat better than the average for the United States in total volume of medical and dental care. No data were available which indicate adequacy of care.
2. Children in metropolitan-adjacent, and isolated counties, received approximately equal amounts of medical care by private physicians.
3. Of the total number of children under medical care (exclusive of newborn), one quarter was under care for health supervision.

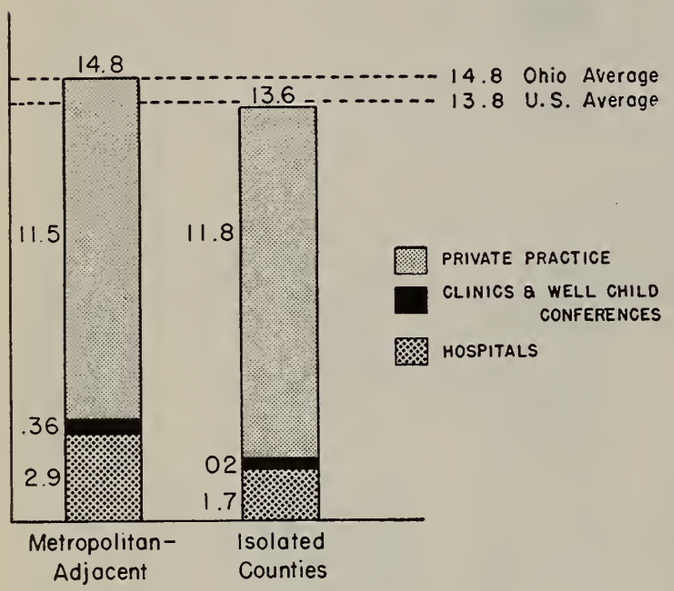
INTRASTATE COMPARISONS OF CHILDREN UNDER MEDICAL AND DENTAL CARE

MEDICAL CARE

Quantitatively, as shown in Figure 6, medical care rendered to children in Ohio (14.8 per 1,000 children) was slightly above the United States

average (13.8 per 1,000 children). When the care in metropolitan-adjacent counties is compared with that received in isolated counties, it seems to be fairly equally distributed. This comparison however gives a false impression. If one studies Figures 9 and 10 showing the distribution of

Fig. 7. Total Volume of Care for Children on one day Per 1000 Children in Metropolitan-Adjacent and Isolated Ohio Counties



medical care according to geographic (Figure 2) and rural groupings (Figure 3), one may readily note certain marked inequalities in care. For example, if one compares the care in the geographic counties, Group VII, with that in Group VI, it may be noted that the children living in Group VII received 45 per cent less medical care than those living in Group VI; that hospital care in Group VII was one quarter (26 per cent) of that in Group VI; and that the total volume of medical care in Group VII was on a par with the fortieth ranking state. (Figures 2 and 3 appeared in the April issue.)

If the amount of care provided by physicians and clinics in the county groupings is compared with the average values for Ohio and for the United States, marked deficiencies become evident:

As to total volume of medical care: (a) By geographic grouping two groups (II and VII) were below the United States average, and five groups (II, III, IV, V, VII) were below the Ohio average. Only two areas (I and VI) were above the general Ohio average; (b) By per cent rural population grouping, three groups (all having 30 per cent or more rural population) were below both the United States average and the Ohio average.

As to care rendered in private practice: (a) By geographic grouping, two groups (Groups II and VII) were below the United States and Ohio averages (Figure 9); (b) By per cent rural population groups, three groups (30 per cent or more rural population) were below the Ohio average. (Figure 10)

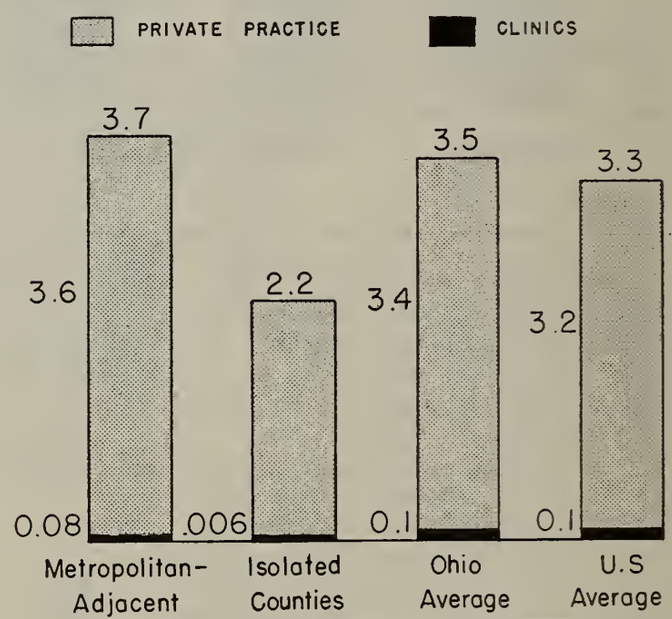
As to care rendered in hospitals: (a) By geographic grouping, four groups (III, IV, V, VII) were below the United States and Ohio averages, and one group (II) was equal to the Ohio average; (b) By per cent rural population, three groups (30 per cent or more rural population) were below both the Ohio and United States averages.

As to care rendered in clinics: (a) By geographic grouping, five groups (II, III, IV, V, VII) were below both the United States and Ohio averages; (b) By per cent rural population, three groups (30 per cent or more rural population) were below both the United States and Ohio averages, and one (under 30 per cent rural population) was essentially the same as the United States and Ohio averages.

DENTAL CARE

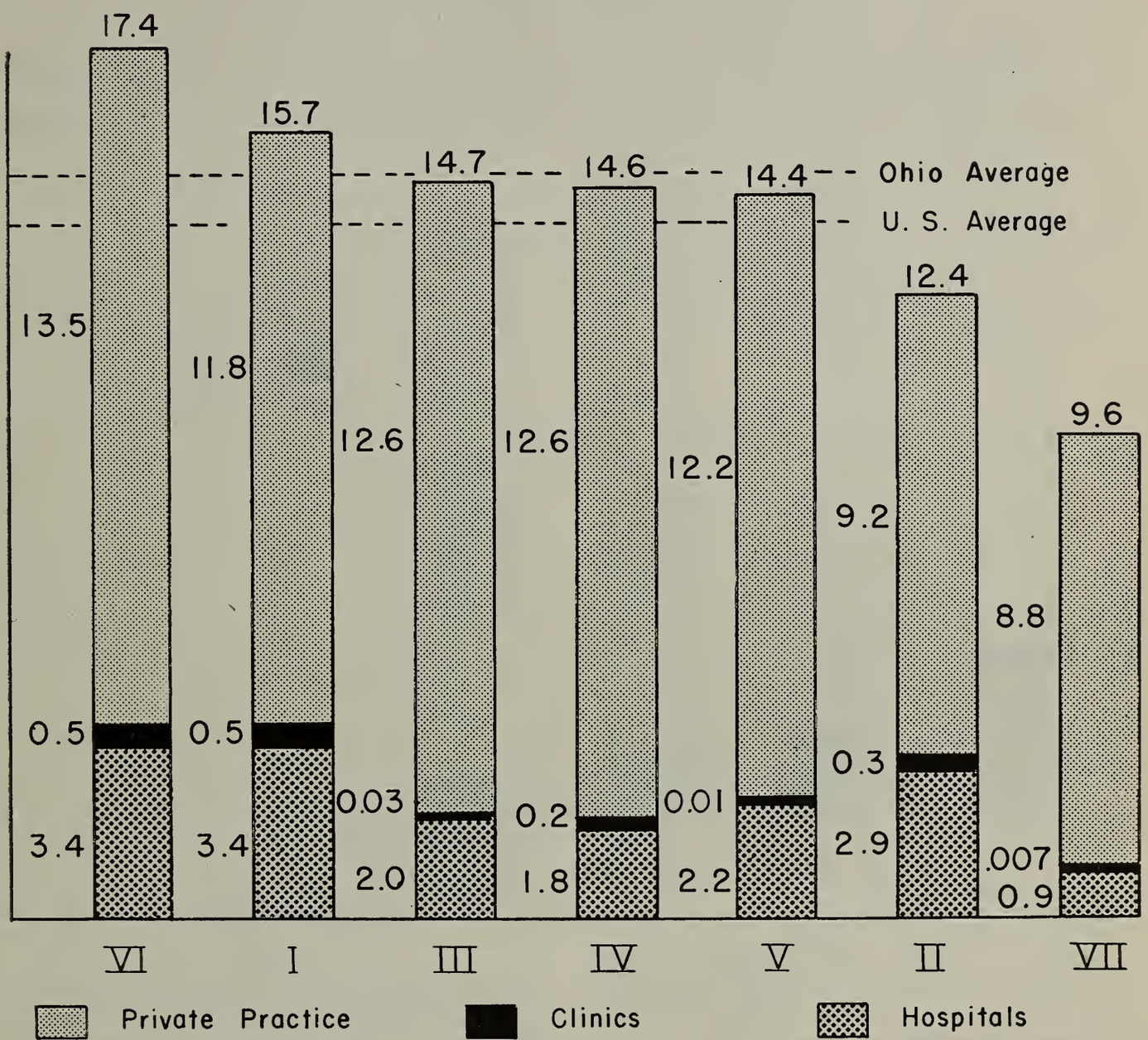
Similar figures (Fgiures 8, 11, and 12) (Figure 12 will appear in the June issue) are given for children under dental care on one day

Fig. 8 Children Under Dental Care on one day per 1000 Children Metropolitan-Adjacent and Isolated Counties, Ohio, Compared with Ohio and U.S. Averages



in Ohio. By comparing the figures, it may be noted that the children in isolated counties received less than two-thirds as much care as those in metropolitan-adjacent counties and as those in the United States generally. Geographically speaking, only those children who lived in geographic Group I had above average care. By per cent rural population groups, all counties having 30 per cent or more rural population had

Fig. 9 Total Volumn of Medical care for Children on one day per 1000 Children By Geographic Grouping, Ohio



below average dental care when compared to the United States and Ohio.

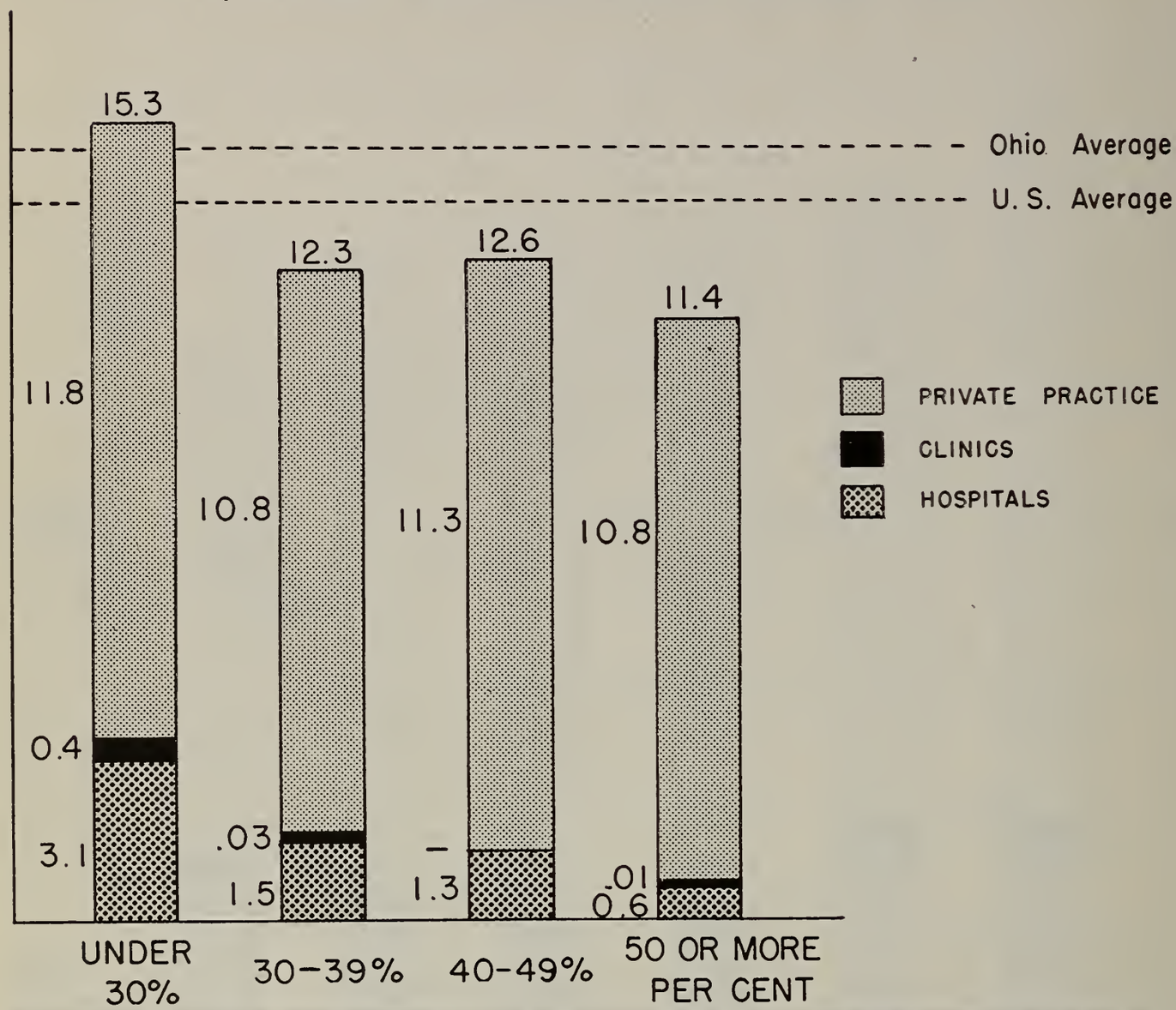
CHAPTER III
HEALTH SUPERVISION

Parents have become educated as to the importance of the role that health supervision plays in the preservation of their children's health. Pediatricians have special training in growth and development of children, feeding and care of well children, and handling of the usual behavior problems encountered in the well-child practice. Many other physicians are also engaged in providing a large portion of this type of care.

Of the total number of visits made by physicians in private practice in one day for well children in the whole state, 74.8 per cent were made by general practitioners, 18.5 per cent by pediatricians and 6.7 per cent by other specialists. Of the general practitioners' total visits to children, 30 per cent was for health supervision including newborn; of the pediatricians, 55 per cent was for this type of care.

Not all health supervision of children is rendered in the private offices of physicians. Well-child conferences have been established for

Fig. 10 Total Volume of Medical Care for Children on One Day per 1000 Children by Per Cent Rural Population Grouping, Ohio



a number of years. Since children of preschool ages are usually the ones attending these conferences the following comparisons are limited to these ages.[7]

The amount of health supervision provided children per day in the county grouping is indicated in the following figures which show the number of children under health supervision per 1,000 children:

Metropolitan	7
Adjacent	5
Isolated semi-rural	4
Isolated rural	4

The rate of health supervision (in private practice and clinics) for children under five years of age was slightly above the average for the United States but only about one-half that of the highest ranking state. (Figure 13) (Figure 13 will appear in the June issue.)

SUMMARY

1. The bulk of child health supervision by private physicians was provided by general practitioners.

2. Thirty per cent of the general practitioners' visits and 55 per cent of the pediatricians' visits were for health supervision.

3. The amount of health supervision in the isolated areas was relatively much less than in the metropolitan counties.

4. Ohio was the eighteenth ranking state in health supervision of preschool children.

CHAPTER IV

PRIVATE PRACTICE

A. PHYSICIANS: NUMBER, TYPE, AND TRAINING

Since the end of World War II, the situation regarding physicians and dentists throughout the

United States has changed. Inasmuch as these data were compiled in September, 1946, the figures may be considerably different since the separation of professional personnel from the armed forces and their return to private practice.

As of September, 1946, there were 6,545 physicians in private practice in the State of Ohio, a ratio of 265 children per physician. In comparison with the rest of the United States, Ohio was the thirteenth ranking state; the highest was New York State with a ratio of 143 children per physician, and the lowest was North Carolina with a ratio of 764 children per physician. The average for the United States was 308 children per physician. Thus it may be seen that Ohio was slightly above the average. The ratio of children per physician has been used in order to show the availability of physicians to children rather than to total population.

The number of children per physician in each of the four county groupings was as follows:

	No. of Children Per Physician	Actual Number of Physicians
Metropolitan	220	4618
Adjacent	386	1053
Isolated semi-rural	338	808
Isolated rural	526	66

Pediatricians—In the State of Ohio, 172 physicians reported at the time of this study that their practices were limited to the care of children. For the purpose of this study, such physicians are classified as pediatricians. This gave a ratio of 10,066 children for each pediatrician, the ratio being slightly better than the United States average of 10,299. Of the 172 pediatricians in Ohio, 94, or 55 per cent were certified by the American Board of Pediatrics. Pediatricians represented less than 3 per cent of the total number of physicians. Ninety-eight per cent of pediatricians were in cities of 10,000 or more population. In Dayton, Cleveland, and Cincinnati, pediatricians represented 4 per cent to 5 per cent of the total number of physicians. No pediatricians were located in isolated rural areas. (Figure 14) (Figure 14 will appear in the June issue.)

Other Specialists—At the time of the survey, there were 2,069 specialists other than pediatricians practicing in Ohio; all but 278 were located in the metropolitan counties The majority of these specialists were in general surgery and internal medicine. The number in each specialty and their certification is shown below.

	Total No.	No. Certified by American Specialty Boards
Internal Medicine[a]	566	173
Allergy	30	6
Psychiatry and Neurology	78	35
Surgery (except orthopedic)[b]	591	131
Orthopedic Surgery	79	46
Obstetrics and Gynecology	210	82
Ophthalmology and Otolaryngology	393	197
Radiology and Anesthesiology[c]	122	65

a. Includes dermatology, syphilology, cardiovascular disease, gastroenterology, and tuberculosis.
b. Includes urology, plastic surgery, neurological surgery, and proctology.
c. Includes clinical pathology and bacteriology.

Training of the General Practitioner—Two thousand one hundred and twenty-two general practitioners gave information as to their hospital training. The amount of training in relation to age is shown in the following table:

Hospital training:	All Ages	Under 45	45 - 64	65+
None or less than one year	19.8%	6.3%	16.5%	62.6%
One year or more—				
None or less than 1 month in pediatrics	24.8	20.0	31.4	21.8
One month or more in pediatrics	55.4	73.7	52.1	15.6

Age, Sex, and Race—Of the 6,545 private practitioners in practice in Ohio, as of September, 1946, 143 were non-white, 185 were women (all white). Twenty of the 172 pediatricians were women. Fifty-four and five tenths per cent of the pediatricians were under 45 years of age, and only 2.4 per cent were over 65. In the other specialties, 49.3 per cent were under 45 and 8.7 per cent were over 65. These percentages in the general practitioners' group were 42.0 per cent and 17.5 per cent respectively.

PHYSICIANS' SERVICES

The county groups are charged individually so that a comparison may be drawn between the physicians' services in the various groups with those in other states.

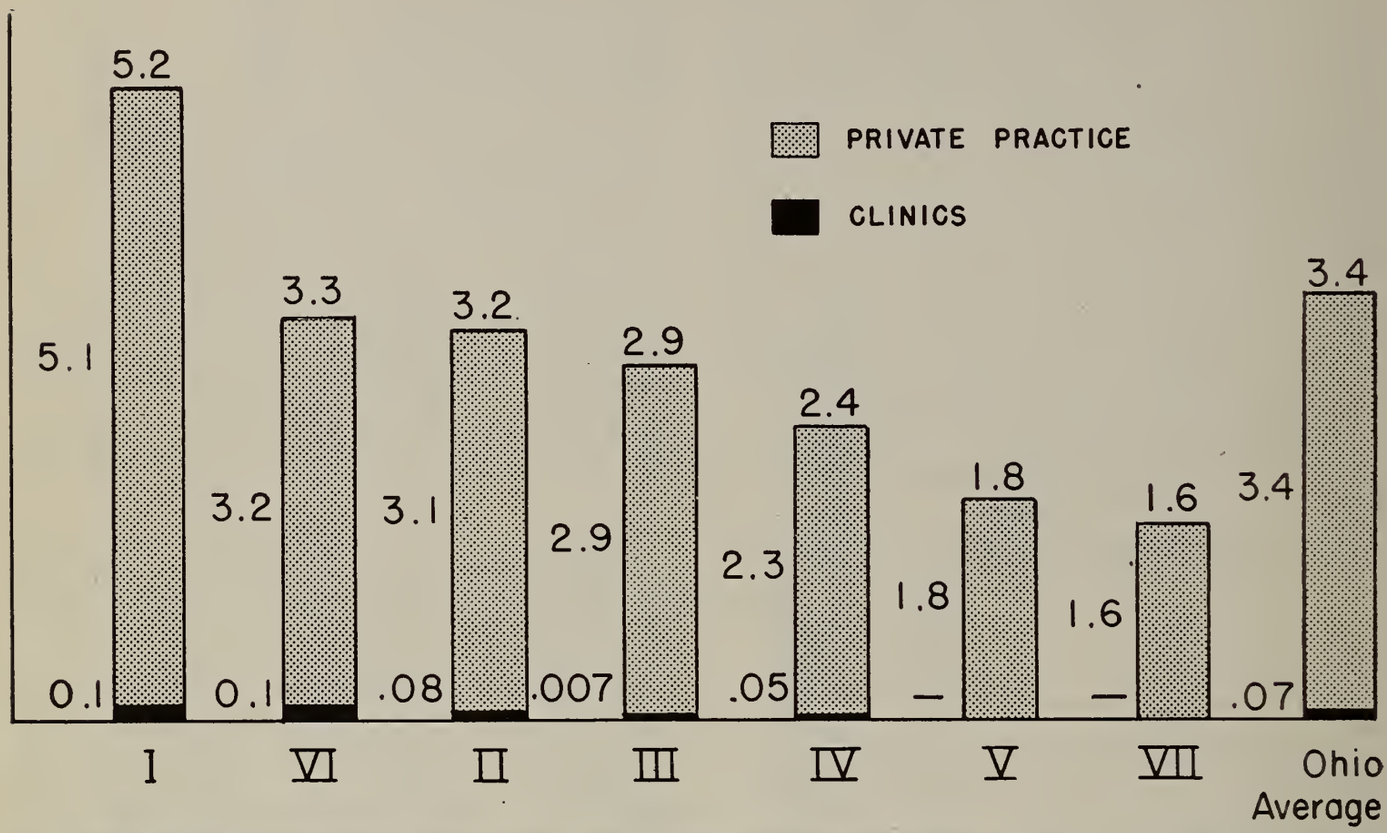
	Physicians' Visits Per 1,000 Children Per Day	Percentage of Ohio Child Population in Each County Group
Metropolitan	15.7	59
Adjacent	14.1	23
Isolated semi-rural	15.1	16
Isolated rural	9.1	2

Average number of physicians' visits per 1,000 children per day was 15.1 for the entire state.

Proportion of Care Rendered by General Practitioners and Specialists—Interesting facts were

Fig. 11 Children Under Dental care on one day per 1000 Children

By Geographic Grouping, Ohio



revealed as a result of reports from physicians throughout the State of Ohio regarding the number of visits in one day. Such visits to children, sick and well, totalled 26,169; of which 74.5 per cent or 19,483, were made by general practitioners, and 10.1 per cent, or 2,647, by pediatricians, and 15.4 per cent by other specialists.

Per Cent of Visits by Type of Practitioner

	General Practitioners	Pediatricians	Other Specialists
Whole State	74.5	10.1	15.4
Greater metropolitan	60.2	17.7	22.1
Lesser metropolitan	66.5	13.4	20.1
Adjacent	89.8	2.3	7.9
Isolated semi-rural	88.1	5.1	6.8
Isolated rural	97.2	---.--	2.8

Although pediatricians represent less than three per cent of total physicians, they made approximately 10 per cent of the visits to children. The pediatricians made 6.5 per cent of the visits to sick children and 18.5 per cent of the visits to well children.

Number of Visits to Patients of All Ages—During the period covered by the study, general practitioners reported seeing an average of 18 patients per day. Five and six-tenths per cent reported an average of 50 visits or more.

Location of Visits—The proportion of office, home, and hospital visits was as follows

Per Cent of Physicians' Visits to Children by Location

	General Practitioners	Pediatricians	Other Specialists
Office	61	62	57
Home	18	17	5
Hospital	21	21	38
Total Visits	100	100	100

It is interesting to note that the percentage of pediatricians' visits at home and the percentage of general practitioners' home visits were very close; the former, 17 per cent, and the latter, 18 per cent. Both groups of physicians saw 21 per cent of their children in hospitals.

REFERENCES

4. Hospital care, a part of total volume, was excluded from well-child care.
5. See Chapter III.
6. Including newborn.
7. Estimated population under five years of age is used in calculating the rates.

(To be concluded in June issue)

Loopholes in Disability Insurance . . .

Physicians Are Advised To Obtain Competent Counsel Before They Purchase Policies in This Highly Competitive Branch of Coverage

AMONG members of the medical profession are many who carry various forms of disability insurance. Because they are good prospects and should have such coverage, physicians often find themselves approached by salesmen who offer their respective policies—many good; some containing a few or many of the "loopholes" referred to in this article.

The buyer often is at a disadvantage in purchasing a contract with as many angles as may be contained in a disability insurance policy. Therefore, the physician is advised to consult an attorney or insurance expert unless he is dealing with an agent whose skill and integrity are known to him.

Mr. Albert Stump, legal counsel for the Indiana State Medical Association, has written an excellent article offering members of the medical profession information and advice on this subject. Following are parts of the article reprinted from the *Journal of the Indiana State Medical Association.*

* * *

Insurance is a highly technical business. The experienced and capable insurance man may be regarded as a professional man. One of the characteristics of a profession is that there develops within it a vocabulary with which the members of the profession become familiar, but with which the layman, with respect to that profession, is not familiar. For that reason **the most important guard against undesirable and inadequate insurance protection lies in the selection of an honest and intelligent insurance agent, personally known to you, who is seriously and studiously making insurance his profession.** Such a man, knowing that he is likely to have to face you and your friends when the situation arises where you expect the insurance as you understood it to come to your aid, is not likely to overstate the protection afforded in the policy he sells you. He does not want to face the tragic result if you find yourself without the protection for which you thought you had paid. Life insurance agents making that calling a profession do not depend to any great extent on disability insurance. Many life insurance companies do not write it. Therefore, the professionally-minded life insurance agents may be more likely to approach your disability problems without bias or prejudice, but with considerable knowledge regarding the whole subject of insurance protection and with your interests paramount.

TYPES OF POLICIES

To illustrate the difficulties the "insurance layman" may have with the insurance man's professional vocabulary your attention is invited to five types of disability income policies being sold. They are:

1. Cancellable policies in general—which may be cancelled at any time before a claim arises or after a claim has been paid.

2. Non cancellable term policies—which generally cannot be cancelled for the year for which the premium was paid and accepted by the company, but which can be renewed after the period covered by that premium only with the consent of the company. **These policies are likely to be particularly misleading.** The company ends its responsibility and terminates the insurance simply by refusing to accept the premium and renew the policy at the end of the year covered by the last premium paid. The reason for calling them non cancellable is that they cannot be cancelled during the year for which the premium was paid, as may be done with cancellable policies.

3. Non cancellable renewable policies—on which renewal premiums may be increased above the premiums formerly paid.

4. Non cancellable renewable fixed-premium policies—which carry definite provisions for increasing the premium in accordance with the increase of the age of the insured and which give the insured the absolute right to renew.

5. Non cancellable renewable level-premium policies—on which the premium remains unchanged and which the insured has the absolute right to renew.

Because of the possibility of confusion and deception in connection with the sale of non cancellable policies where right of renewal depends on the consent of the company, some states have prohibited by law the sale of such policies as non cancellable policies. Too many will not realize that the policy may be ended by the refusal of the company to renew it. The result is the same as if the policy could be and was cancelled.

INSURED AGAINST WHAT?

A technical feature that is almost certain to escape consideration by the layman buying accident insurance is to be found in the insuring

clause. That is the part of the policy that states the **conditions under which the benefits of the policy are to be paid.** These clauses vary in different policies. One of the important questions regarding that clause is whether the company pays because of bodily injury **"received through accidental means,"** or because of **"accidental bodily injury."** The first clause covers unintended means—that is, the means bringing about the injuries must be unintended. For instance, in Kendall v. Travelers Insurance Company, 87 Oregon 179, the court held that an abrasion by a barber as a result of his attempting to remove ingrowing hair at the request of the insured was not an accidental but was an intended means, and therefore the results of removing the ingrowing hair did not come within the insuring clause.

Another court held that shaking down ashes in a furnace from which the insured was injured was not covered because the means was intentional. In another case it was held that infection arising from rubbing a toe with a towel, which resulted in a bodily injury, did not involve an accidental means.

On the other hand, if the insuring clauses in these disability policies covered "accidental bodily injury" the policies would have covered the injuries sustained.

Another highly technical and often controversial question is, when is a person disabled? Is it only when he is unable to do anything at all, or only when he is confined to his house, or only when he is confined to a bed? If it requires that he be confined continuously within doors, then if he sits in the yard or on his porch or makes an automobile trip his disability benefits are terminated. Suppose a person suffers a stroke of paralysis, as a result of which he is impaired to the extent that he cannot carry on his business. **If his disability policy contains a house confinement clause he would be compelled to stay in his house for the rest of his life if his financial condition required him to depend on his disability benefits.** If disability means inability to perform all the usual tasks connected with his regular profession or employment, one situation exists; but if it means only some one or more essential duty in order to carry on his profession, another situation exists.

THE POLICY, NOT THE ADVERTISING, CONTROLS

This should be sufficient to indicate the highly technical elements in insurance. **But insurance is often sold by the advertising, by the oral persuasion of the agent, or by the recommendation of some other person** who himself may not have taken the time to check the policy against a definite outline for analysis which would disclose its actual merits and demerits. It should be remembered that **the insurance company is not bound by the statements of its agents. The policy itself is the contract which establishes the obligation of the company.** An analysis of the policy sometimes discloses that the policy falls far short of what the physician or other buyer of insurance thought it was. He listened too intently to the statement of agents or the recommendation of friends, or read the advertising with too much credulity. There is but one means of determining what the company's obligations are, and that is an accurate analysis of the policy itself. **If any agent refuses to give you a specimen copy of a policy for study and analysis by one who is competent in that work, you can be sure that there is some reason for withholding the sample policy other than the best interest of the person being solicited.**

The physician or other person buying disability insurance should not expect any financial miracles from the company. **The company cannot remain solvent if it gives benefits greater than are paid for in the premium.** A few statistics will indicate the limitations on benefits that can be paid where premiums are low enough that the policy can be sold. Disability insurance should be regarded as protection against what might otherwise be a calamity. To go beyond that is inadvisable, as a few statistics will demonstrate. According to reliable statistics there are 662 cases of disability per 1,000 of population each year in the United States; that is, two out of every three are disabled, if by being disabled is meant that one or more days work is lost because of illness or injury. So in the figure 662 will be included everything causing any loss of time, whether for a single day or for an entire life time Only 75 of the 662 disabilities per year result from accident. The remaining 587 are caused by sickness. Obviously any policy covering policy-holders so completely that two out of every three would collect each year under their policies for disabilities ranging from one day to the entire lifetime would require such a prohibitive premium that not enough sales could be made to make the business succeed.

SOME PITFALLS IN SPECIAL POLICIES

Insurance is a highly competitive business. **Occasionally insurance companies try to gain a competitive advantage by making their policies appear to offer more than they really do.** They may promise complete protection from the first day of disability and then include exclusions of certain ailments from the coverage. They may permit cancellation of the policy or termination of it by refusing to renew the policy at the expiration of the time covered by the last premium paid. They may pay only while the person is totally disabled or continuously house confined. These mentioned limitations on liability of course do not exhaust the limitations that may be included in a policy which may overemphasize some desirable feature which is more

than made up for by undesirable limitations and exclusions.

One of the means by which some companies try to meet competition is by claiming that they are giving group insurance to special classes, when in fact what they are offering does not constitute true group insurance. True disability group insurance is insurance which does not become effective until a certain percentage of the members of the group have subscribed for policies all of the same kind. Thus if a company were to write disability group insurance on the medical association it would be such insurance as would become effective only when some definite percentage of the whole association had subscribed for and been issued the same kind of policy—or, for convenience sake, had issued one master policy with certificates of interest to the individuals in that master policy.

There is a type of group insurance which is sometimes referred to as "franchise group insurance." A franchise, as a matter of law, is a privilege or right which may be granted to one or more but is not given to the whole public. For instance, a policy might be specially worked out for members of the medical profession which other professions or the public at large could not obtain. The company giving the right or privilege —or in legalistic language, the franchise—would not give the same policy to those who were not in the group receiving the franchise from the company. Some insurance companies have attempted to meet competition by marking their regular policies as special policies for some group or other when the fact is that any other group or profession, or even any member of the public at large, could buy exactly the same policy for the same premium. Yet the idea that is implanted in the mind of the member of the profession who looks at an application blank with the words in large letters to the effect that the policy is one available only to those who are members of his particular profession is that he is getting something special—something better than the general public, or those not a member of his group, could get for the same money

Still another of the means by which companies seek to make it appear that they are **offering something better for a lower price** than their competitors offer is to offer a franchise group policy declared to be non cancellable and renewable without the consent of the company, **and then include in that policy exceptions** under which all the policies issued to that franchise group may be cancelled or the right of renewal refused. Suppose you obtain a franchise group policy of that kind. The company may carry along and continue to renew the policy until the increase of the average age of those who have obtained such a policy brings the group into the place where there is a heavy cost in carrying the insurance further. Then the company may refuse to renew everybody in that group and all of them will have their disability insurance thereby terminated at a time when they have grown older, been afflicted by disease, and become uninsurable. Just when they need the insurance it may be cut off. This plan could be carried out only partially, by the company writing new policies for those who still continue as desirable risks and then cancelling all the original policies in the original franchise group.

CONCLUSION

This article has been written with the sole purpose of attempting to give to the members of the association at least enough understanding of disability insurance programs that they will realize that these problems fall within a specialized business where service of a professional nature should be had. Fortunately, such service is generally available through your own locally established insurance agents who are making of their work a serious profession, or it may be obtained through legal counsel.

Infant Mortality Reaches All-Time Low in 1947

The infant mortality rate in 1947 was the lowest on record, according to figures released by the National Office of Vital Statistics of the Public Health Service. The number of deaths under one year recorded in the United States during 1947 was 119,173, or 8,110 more than the number (111,063) reported in 1946. However, this increase reflects the tremendous increase in the number of births during 1947 and not a rise in infant mortality. The relative frequency of infant deaths as measured by the infant mortality rate decreased from 33.8 per 1,000 live births in 1946 to 32.2 in 1947. Provisional figures indicate a further decline in 1948 to an estimated rate of 31.8.

The five leading causes of infant deaths in 1947 and the infant mortality rates for each are: premature birth, 11.1; congenital malformations, 4.6; pneumonia and influenza, 3.6; injury at birth, 3.5; and asphyxia and atelectasis, 1.6. These leading causes accounted for 75.7 per cent of all the infant deaths in 1947. This was the first year that asphyxia and atelectasis ranked among the five leading causes of infant deaths and that diarrhea, enteritis, and ulceration of the intestines has not been in this group.

Dr. Ralph Gregg, who during the war was stationed in Columbus as Public Health Service liaison officer to the Army headquarters there, has been appointed assistant chief of the Foreign Quarantine Division of the Public Health Service, Federal Security Agency. He succeeds Dr. Frederick W. Kratz who has been assigned to the P. H. S. office of F. S. A. Region 3 in Washington.

On the Firing Line . . .

Shots At Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"The standard of living for middle class (British) people is low because of the over-load of socialized medicine and other state aid."—*Fred G. Clark, chairman of the Economic Foundation of New York.*

* * *

"If the Federal Government socializes hospitals and doctors, other professions and business in general will be sure to follow. The inevitable result of socialization will be a lower standard of living."—*Alfred P. Haake, economist-consultant, General Motors Corporation.*

* * *

"Compulsory health insurance has cost Europe the world leadership in medical science . . . Until 30 years ago, American doctors went to Europe for their post-graduate work. With the deterioration of the quality of medical practice in Europe under compulsory health insurance, European doctors now come to the United States to do their post-graduate work."—*Major General Paul R. Hawley, executive officer of the Blue Cross-Blue Shield Commissions.*

* * *

"This compulsory health insurance plan of the administration is no social experiment. It is final surrender. Let government take over the major responsibility for distributing and financing medical care, and there will be no turning back, no matter how great the confusion or how great the disappointments. The old patterns will have been broken once and for all. The eggs cannot be unscrambled."—*The Milwaukee Journal.*

* * *

"The text of Senate Bill 5, with that of its counterparts in the House of Representatives, presents its own best commentary. It is an 84-page maze of obscure passages, deliberately clouded meanings, tricky phrases, and legalistic mumbo jumbo which is intended to hide the real significance of the proposed program. The authors of the bill play the seedy trick of not spelling out the legislation, leaving important problems of administration to the ever amenable rules and regulations."—*Journal of the American Dental Association, April, 1949.*

"Here the dangers of epidemic disease are less than in any country of the world. Pneumonia has been licked. Tuberculosis is off the list of major killers, with the day in sight when it may be wiped out entirely. Thousands of scientists carry on the war against cancer. Diseases of the heart are yielding to research and education. So on in every field.

"Now, however, there is a subtle campaign on foot to discredit the accomplishments of the medical profession. It stems, of course, from the boys 'who can do it better,' the bureaucrats who would like to see medicine socialized, controlled, and regulated.—*The New York Daily Mirror.*

* * *

"In New Zealand, political medicine set up 10 years ago now takes 40 per cent of all revenues collected by the government, leading to a deficit financing already. Forty per cent of comparative revenues in the United States would come to 15 billion dollars a year."—*Tom Ireland in the Cleveland Plain Dealer.*

* * *

"(Under Compulsory Health Insurance) every worker in this country will have the cost subtracted from his pay envelope, and added (by his employers) to the price of everything he buys. He will be paying for unused aspirins when he needs money for oranges. He will be supporting innumerable filing clerks—a horrendous paper staff for 150,000,000 people."—*Dorothy Thompson.*

* * *

"Hospitalization insurance is such a relative newcomer to the American scene that its development may properly be regarded as in an early stage. Despite this fact more than one-third of all the people in the country are protected against the expense of a hospital confinement. There can be only one deduction from these figures—that the public emphatically does find private health insurance plans both attractive and feasible."—*The Columbus Dispatch.*

* * *

"All the undertakings of the socialist government show one thing with melancholy montony —increased cost. The official figures, just issued,

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for the National Health Service are no exception. The cost of doctors is $118,000,000, an excess of $9,200,000 over the estimate. The cost of dentists is $82,800,000, an increase of $54,600,000. The cost of pharmacists is $70,860,000, an increase of $20,000,000 over the estimate. The cost of opticians is $57,800,000, an excess of $15,000,000 over the estimate. A large part of this vast expenditure is wasted, as is so characteristic of socialist finance.—*London correspondent, Journal of American Medical Association, April 2, 1949.*

* * *

"Let Social Security Administrator Ewing lay his socialist hand on one single doctor, and he will do so to your peril—whoever you may be and whatever work you may do—and to the peril of this country. For if doctors can be socialized, why cannot dairymen be socialized? More people need milk every day than need doctors. Why cannot any business be nationalized?"—*Henry J. Taylor, economist, author and journalist.*

* * *

"There is a kind of dictatorship that comes about through a readiness to accept paternalistic measures from the government. With these, there can come a surrender of our own responsibilities and therefore a surrender of our own thought over our own lives.

"There will be a swarming of bureaucrats over the land; ownership of property will gradually drift into that central government, and finally you will have to have dictatorship as the only means of operating such a huge organization."—*General Dwight D. Eisenhower.*

* * *

"In Europe, health insurance programs were followed by the socialization of railroads of private insurance companies, of land, of public utilities, of some industries. New Zealand has socialized banking, the dental profession, the druggist, the airways, and last year an attempt was made to socialize the farmer."—*Dr. Eugene A. Ockuly in the Bulletin of the Toledo Academy of Medicine.*

* * *

"Extravagant tax demands by the Federal government constitute a dangerous drain on family income and are forcing lower living standards on millions of American people . . . It's a little hypocritical, under the circumstances, for Federal Security Administrator Oscar Ewing to be beating the drums for compulsory health insurance as a cure for the people's ills.

"If he wants to make a real contribution toward improving the public health in America, he should do something about cutting costs in his own towering bureaucracy and in other departments in Washington which are literally taking food out of the mouths of the people. In lower income groups, malnutrition is at the bottom of much of the disease in America and Oscar Ewing should know it."—*Dr. R. B. Robin, Camden, Arkansas, member of the House of Delegates, American Medical Association.*

* * *

"A federalized system of compulsory insurance will not result in a saving of lives and a reduction of the cost of health care for the majority of families. On the contrary, governmental restrictions, controls and interferences between practitioner and patient, will lower the standards of medical, dental and nursing care, and unquestionably will result in an increased death rate and prolonged illness for many persons."—*Allen O. Grubbel, in the Journal of the American Dental Association, April, 1949.*

* * *

"The incentive and the ability necessary for any doctor to excel in his field is solidly based on the freedom of the individual patient to choose his physician. Where patients can no longer choose their doctors on the basis of merit, there will be a decline of incentive on the part of doctors.—*Tom Ireland in the Cleveland Plain Dealer.*

* * *

"We in the United States are leading longer, healthier lives. Diseases which were almost sure killers not so many years ago now offer little danger. A system of voluntary prepaid medical care has been built up which brings the cost of treatment and hospitalization within easy reach of the majority of people. These are achievements of free medicine which must not be forgotten."—*Journal-Courier, Lafayette, Ind.*

* * *

"In spite of the gripes that are always bound to be heard, the vast majority of our 140,000,000 people are fully aware that we have the best goldarned standard of living and way of life in the world."—*General Dwight D. Eisenhower.*

* * *

". . . The cost of the program already is running far higher than expected and the outlook is that it will increase year by year. And already the basic British income tax rate is 45 per cent. Economists are warning the government that there is a point beyond which general government revenue can be milked to support the plan in addition to the approximate one dollar a week each British citizen pays for what he is told is 'free medical care.' The fiscal experts also are telling the government that 'the burden of social services assumed by the Socialist Government may become heavier than the national economy can carry.' "—*The Columbus Dispatch.*

County Officers' Conference . . .

Discussions on Vital National and State Health Legislation, and the Profession's Public Relations Programs Draw Large Group to Columbus

MORE than 175 persons who attended the Annual Conference of County Medical Society and Ohio State Medical Association Officers and Committeemen in Columbus, March 20, heard "on-the-scene" discussions of state and national legislative outlooks, and at the same time were briefed on how the A. M. A. and the State Association are correlating their public relations programs to fill present needs.

Dr. A. A. Brindley, President of the Association, presided and summed up the purpose of the meeting with an appeal for every doctor in Ohio to promote the medical profession's positive program for the future health and welfare of the American people.

Lead-off guest speaker was Mr. Gerald G. Gross, representative of the American Medical Association in Washington, D. C., whose subject was, "What's Going on in Washington and the 81st Congress." Mr. Gross presented an on-the-scene review of the present Congress, with an abundance of practical information gained from personal contact in the Capital.

The local scene on the legislative front was presented by Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, whose subject was, "What's Going on in Columbus and the 98th Ohio General Assembly." Mr. Nelson briefed a number of the more than 50 bills on health, medicine and related subjects now before the General Assembly. He stressed the importance on the part of committees of county medical societies in promoting progressive legislative programs and of keeping representatives posted on how the medical profession stands on current legislative matters.

An important period in the conference was that devoted to district conferences. At these 11 conferences, presided over by respective Councilors, doctors discussed means of advancing legislative and public relations programs within their areas.

Following the dinner, Mr. Lawrence Rember, of Chicago, director of public relations for the A. M. A., explained the stepped-up program made possible through the $25 membership assessment. He gave those present a look into the program soon to be launched under direction of the public relations firm of Whitaker and Baxter. Mr. Rember stressed the need of coordination of state and local organizations' programs with that of the A. M. A. The national program, he assured, will be a positive plan with stress on the proposed 12-point program of national health.

Mr. George H. Saville, Columbus, director of public relations for the Ohio State Medical Association, spoke on "Public Relations Activities of the Ohio State Medical Association." He outlined the program approved by The Council and presented in the April issue of *The Journal.* Mr. Saville pointed out that the state program is a progressive one, correlated with the A. M. A. plan, and one that calls for cooperation on the part of county medical societies and individual doctors throughout the state.

"Information Please" periods were interspaced in the conference program, during which speakers were questioned and open discussions were held.

Those registering at the conference were the following:

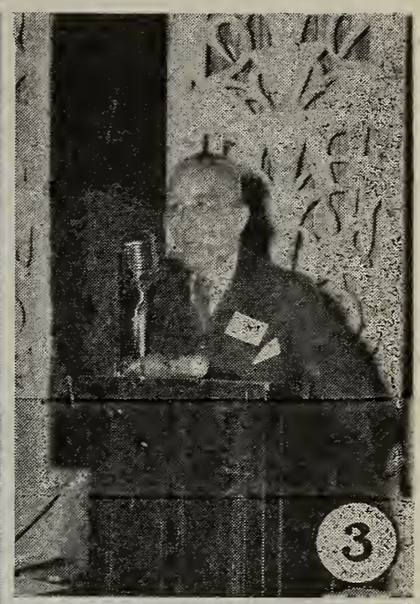
Dr. A. A. Brindley, Toledo, President; Dr. Carl A. Lincke, Carrollton, President-Elect; Dr. R. L. Rutledge, Alliance, Past-President; Dr. H. P. Worstell, Columbus, Treasurer; Councilors, First District, Dr. E. O. Swartz, Cincinnati; Second District, Dr. H. C. Messenger, Xenia; Third District, Dr. J. Craig Bowman, Sandusky; Fourth District, Dr. Carll S. Mundy, Toledo; Fifth District, Dr. Fred W. Dixon, Cleveland; Sixth District, Dr. Paul A. Davis, Akron; Seventh District, Dr. R. J. Foster, New Philadelphia; Eight District, Dr. Chester P. Swett, Lancaster; Ninth District, Dr. J. P. McAfee, Portsmouth; Tenth District, Dr. H. M. Clodfelter, Columbus; Eleventh District, Dr. John S. Hattery, Mansfield.

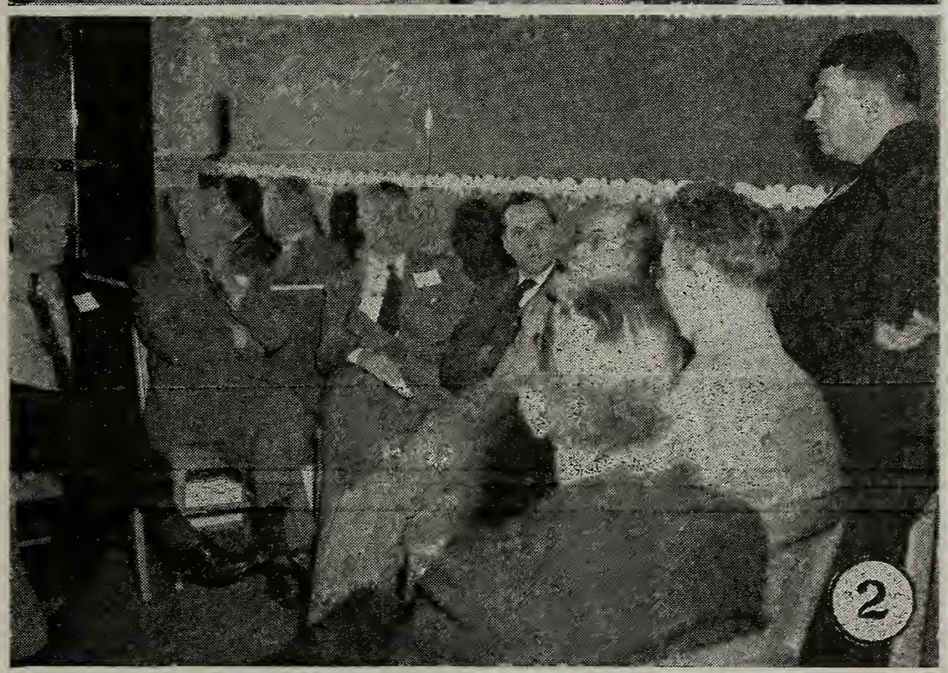
Adams—Dr. Hazel L. Sproull, West Union. **Ashland**—Dr. R. J. Ferguson, Ashland. **Athens**—Dr. Beatrice Postle, Athens; Dr. J. L. Webb, Nelsonville. **Auglaize**—Dr. Harry Geisler and Dr. Elizabeth Kuffner, St. Marys. **Belmont**—Dr. Leo D. Covert and Dr. D. M. Creamer, Bellaire; Dr. Bertha M. Joseph and Dr. R. H. Wilson, Martins Ferry. **Butler**—Dr. John F. Borelli, Hamilton. **Champaign**—Dr. D. C. Houser, Dr. F. E. Lowry and Dr. I. Miller, Urbana. **Clark**—Dr. W. D. Beasley, Dr. E. W. Schilke, Dr. R. M. Turner, and Dr. N. S. Wright, Springfield. **Clermont**—Dr. J. M. Coleman, Loveland; Dr. Allan B. Rapp, Owensville; Dr. George E. Rockwell, Milford.

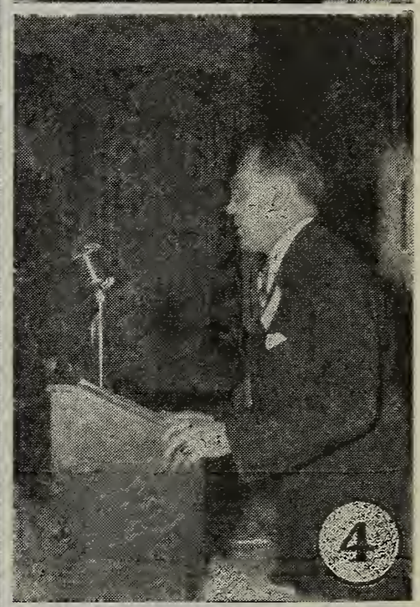
Clinton—Dr. Robert Conard, Wilmington. **Columbiana**—Dr. C. J. Maxwell, Wellsville. **Coshocton**—Dr. H. W. Lear, Coshocton. **Cuyahoga**—Dr. Francis Bayless and Dr. John D. Osmond, Cleveland. **Darke**—Dr. E. R. Irwin, Bradford; Dr. John S. Meyers, Versailles. **Defiance**—Dr. D. J. Slosser, Defiance. **Delaware**—Dr. A. B. Callander, Delaware; Dr. Harold W. Davis, Ashley; Dr. F. M. Stratton, Delaware. **Erie**—Dr. H. G. Lehrer, and Dr. E. J. Meckstroth, Sandusky. **Fairfield**—Dr. H. M. Amstutz and Dr. Arthur B. Van Gundy, Lancaster. **Fayette**—Dr. James E. Rose and Dr. M. H. Roszmann, Washington C. H. **Franklin**—Dr. Thomas R. Curran, Dr. Drew Davis, Dr. Jonathan Forman,

Conference of State and County Officers and Committeemen

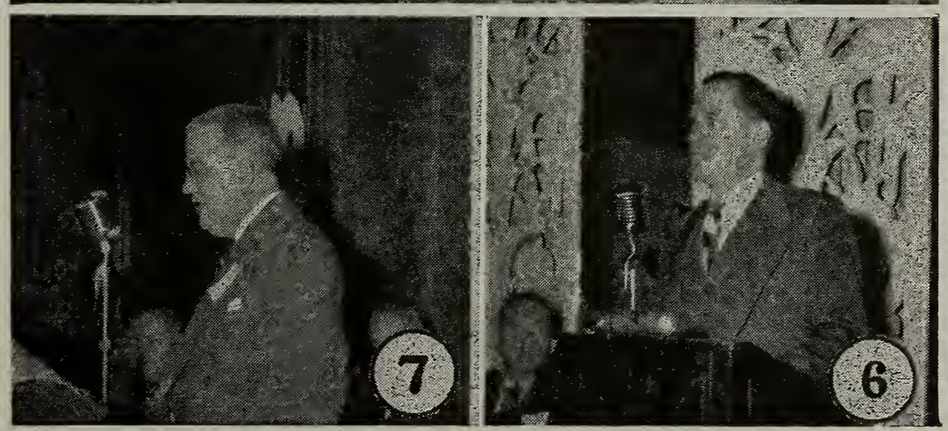












1. Approximately 175 doctors attended the conference and enjoyed this luncheon atmosphere at the Hotel Fort Hayes in Columbus.

2. Councilor District conferences were an important part of the meeting. Here Dr. R. J. Foster (seated at right with hand to chin) presides over the Seventh District session. Standing at right is Dr. Carl A. Lincke, President-Elect of the Association.

3. Dr. A. A. Brindley, as President of the Association, presided over the conference.

4. Mr. Lawrence Rember, public relations director of the A. M. A., outlined the national program.

5. Mr. Charles S. Nelson, Executive Secretary, briefed conferees on the legislative front in Ohio.

6. Mr. Gerald G. Gross, outlined happenings in Washington.

7. Mr. George H. Saville, public relations director for the Association, discussed the public relations activities in the State.

DETAILED REPORTS OF THE ANNUAL MEETING TO BE GIVEN IN JUNE ISSUE

The time element prevented including in this issue of *The Journal* important activities at the Annual Meeting of the Ohio State Medical Association which was held in Columbus April 19-22. The last section of the May issue was made ready for the press before the start of the meeting. Members will find detailed reports of the many activities, including proceedings of The House of Delegates and The Council, in the June issue.

Dr. Grant O. Graves, Dr. Gilman D. Kirk, Dr. Dwight M. Palmer, Dr. Claude S. Perry, Dr. H. M. Platter, Dr. J. D. Porterfield, Dr. Clark P. Pritchett, Dr. Thomas E. Shaffer, Dr. C. C. Sherburne, and Dr. Robert Young.

Gallia—Dr. N. H. Foster and Dr. Homer B. Thomas, Gallipolis. **Guernsey**—Dr. William L. Denny, Cambridge. **Hamilton**—Dr. Louis G. Herrmann, Dr. H. G. Reineke, and Dr. R. C. Rothenberg, Cincinnati. **Hancock**—Dr. T. R. Shoupe, and Dr. Frank Wiseley, Findlay. **Hardin**—Dr. S. P. Churchill, Kenton. **Highland**—Dr. J. Martin Byers, Greenfield. **Huron**—Dr. C. J. Cranston, Wakeman. **Jackson**—Dr. Garrett B. Ackerman, Wellston; Dr. Elizabeth C. Innis, Jackson. **Jefferson**—Dr. Walter Cunningham. **Knox**—Dr. J. W. Allman, Centerburg; Dr. John L. Baube, Mt. Vernon. **Lake**—Dr. Frederick J. Dineen, Dr. C. B. Elliott and Dr. Paul E. Reading, Painesville. **Licking**—Dr. G. A. Gressle, Newark. **Logan**—Dr. Omar C. Amstutz, Bellefontaine. **Lorain**—Dr. S. J. Birkbeck and Dr. S. D. Nielsen, Elyria. **Lucas**—Dr. A. L. Bershon, Dr. Martin W. Diethelm, Dr. Howard Holmes, Dr. C. E. Hufford, Dr. Foster Myers and Dr. Eugene A. Ockuly.

Madison—Dr. Sol Maggied, West Jefferson. **Mahoning**—Dr. Edward J. Reilly, Campbell; Dr. W. M. Skipp, Youngstown. **Mercer**—Dr. R. G. Schmidt, Celina. **Miami**—Dr. Don F. Deeter, Troy; Dr. G. A. Woodhouse, Pleasant Hill. **Montgomery**—Dr. Roy S. Binkley, Dr. R. K. Finley, and Dr. Reid P. Joyce. **Muskingum**—Dr. Lester Lasky, Dr. George C. Malley, Dr. Robert S. Martin, and Dr. H. C. Powelson, Zanesville. **Ottawa**—Dr. LeRoy L. Belt, LaCarne; Dr. C. R. Wood, Port Clinton. **Perry**—Dr. H. F. Minshull, New Lexington; Dr. W. D. Porterfield, Junction City. **Pickaway**—Dr. W. F. Heine, Circleville. **Putnam**—Dr. W. B. Recker, Leipsic.

Richland—Dr. P. A. Blackstone, Bellville; Dr. Wallace H. Buker, Dr. Robert R. Crawford, Dr. Carl R. Damron, Dr. Charles R. Keller, and Dr. F. M. Wadsworth, Mansfield. **Ross**—Dr. R. C. Bane, Chillicothe. **Scioto**—Dr. C. L. Pitcher, Portsmouth. **Seneca**—Dr. G. H. W. Bruggemann, Fostoria. **Stark**—Dr. L. E. Anderson, Greentown; Dr. John E. Dougherty, Canton; Dr. J. R. Rohrbaugh, Massillon; Dr. R. E. Tschantz, and Dr. John M. Van Dyke, Canton. **Summit**—Dr. J. G. Kramer and Dr. L. A. Witzeman, Akron.

Trumbull—Dr. Chas. W. Mathias, Niles. **Tuscarawas**—Dr. James S. Adler, Strasburg; Dr. Jay W. Calhoon, Uhrichsville; Dr. C. M. Daugherty, Dr. Burrell Russell and Dr. Harold F. Wherley, New Philadelphia. **Union**—Dr. Fred Callaway and Dr. A. M. Johnston, Marysville. **Van Wert**—Dr. G. A. Edwards, Dr. Thomas L. Edwards, and Dr. R. E. Shell, Van Wert. **Warren**—Dr. Orville L. Layman, Franklin. **Williams**—Dr. J. A. Maxwell, Montpelier. **Wood**—Dr. Paul F. Orr, Perrysburg. **Wyandot**—Dr. H. K. Van Buren, Carey.

Executive secretaries and others attending in an official capacity included: Messrs. Frank C. Bateman, Clark County; H. Van Y. Caldwell, Cleveland; Robert W. Elwell, Toledo; R. F. Freeman, Montgomery County; Stanley R. Mauck, Columbus; Ray A. Swink, Cincinnati; Charles H. Coghlan, Ohio Medical Indemnity, Inc.; Messrs. Nelson, Saville, Page and Moore of the Columbus Headquarters Office.

Ohio Supreme Court Upholds Medical Board in Ferrand Case

The Ohio Supreme Court recently reversed the decision of the Court of Appeals for Franklin County in the case of J. H. Ferrand vs. the State Medical Board, and thereby upheld the Board in its revocation of Ferrand's license to practice chiropractic and mechanotherapy.

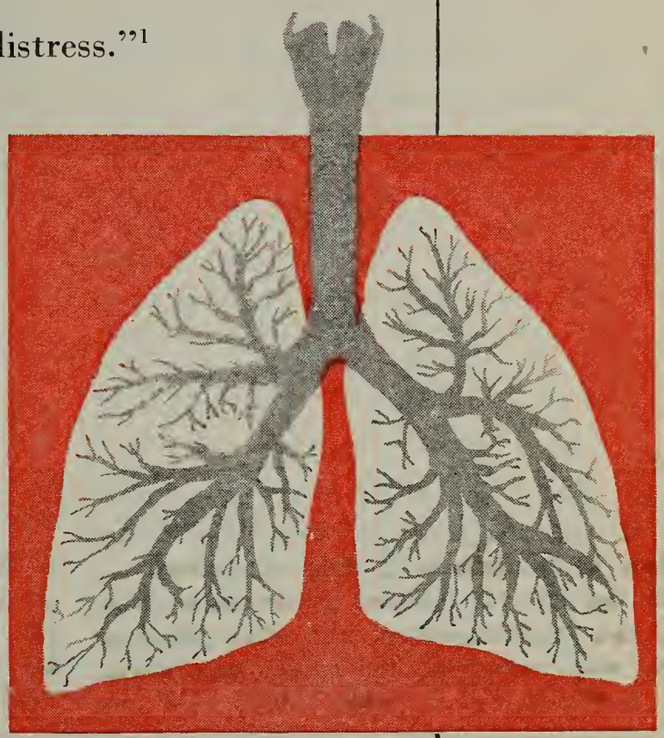
"The Court of Appeals held that the trial court committed error in considering and deciding the appeal from the decision of the State Medical Board as an appeal on law instead of considering and deciding it upon its merits as an appeal on law and fact. In so holding, the Court of Appeals was in error," the opinion of the Supreme Court stated.

"In providing for an appeal from the decision of such a board or commission, the General Assembly did not intend that a court should substitute its judgment for that of the specially created board or commission but did intend to confer a revisory jurisdiction on the court," the decision further states. "Otherwise, the section would not have contained the provision, 'in the hearing of the appeal the court shall be confined to the record as certified to it by the agency, provided, however, the court may grant a request for the admission of additional evidence when satisfied that such additional evidence is newly discovered and could not with reasonable diligence have been ascertained prior to the hearing before the agency.'

"We are of the opinion that this last-quoted provision is inconsistent with a *de novo* hearing whereby the court substitutes its judgment for that of the agency which heard the facts."

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Murphy, F. D.: Treatment of Cardiovascular Emergencies in the Home. Wisconsin M. J. 42:769 (Aug.) 1943

'Voluntary' Health Insurance Bill . . .

Proposed Legislation Would Encourage Expansion of Present Facilities In Contrast to Ewing's Drastic Compulsory Sickness Insurance Plan

THERE has been introduced in the U. S. Senate a bill, S. 1456, which the authors assert will perform the same service for financing hospital and medical care that the Hill-Burton Survey and Construction Act is now doing in the building of hospitals.

The "Voluntary Health Insurance Bill," as it is called, was introduced by Senator Lister Hill of Alabama, one of the sponsors of the Hill-Burton Act, who has gone on record as opposed to such drastic proposals as a compulsory health insurance program. He asserted that "a compulsory system of health insurance carries within it the danger of uprooting and destroying the entire system of medical practice in this country."

Like the Hill-Burton Act, the proposed new bill would make available funds to defray part of cost of the program and would leave the states free to participate if they so elected.

"Under the bill the Federal government gives financial aid, encouragement, and wise guidance from its vast resources, its broad experience, and its facilities for technical study and research," the author stated. "Under the bill the control and administration of the program rests with the states and their communities, adapted to local needs and local conditions."

The proposed legislation seemingly encompasses a "middle course" effort for a comprehensive health program. It lies somewhere between the purely voluntary prepayment hospital and surgical insurance programs and the radical compulsory sickness insurance program proposed by Mr. Ewing.

In it are embodied many of the principles proposed by Dr. Gilson C. Engel, president of the Medical Society of the State of Pennsylvania, in his ten-point program, and was drafted after an extensive conference between Senator Hill and Dr. Engel. Co-authors of the bill with Senator Hill are Senators O'Connor of Maryland, Withers of Kentucky, Aiken of Vermont and Morse of Oregon.

Provisions of the bill are broad and general in many instances. Flexibility anticipates future developments.

PROVISIONS FOR INDIGENT

The first and immediate purpose of the bill is to provide protection for people of limited income by giving them service cards in voluntary prepayment plans which will entitle them to the same kind of hospital and medical care as those who are able to purchase such protection on a voluntary basis.

Another basic purpose of the bill is to encourage every citizen to protect himself against the costs of hospital and medical care through voluntary enrollment. The bill states that a participating state shall "provide for a survey of existing enrollment in participating voluntary prepayment plans and development of a plan for stimulating and encouraging enrollment in such plans by all persons able to pay subscription charges, with emphasis on employer participation and enrollment of persons in rural areas."

In commenting on the advantages of his bill in contrast to a compulsory sickness insurance program, Senator Hill said:

"We believe that the present system of medical care has been too valuable, too effective and too useful through the years, to throw it aside for a new system which might not work. We believe it is the course of wisdom first to examine our existing health and hospital and medical resources, then to proceed with the building and strengthening of them where that is necessary to bring adequate health care to all the people.

ABHORS INFERIOR SYSTEM

"The last thing we want in this country is an abundance of poor hospitals and poor medical care. Our existing system has produced a quality of care which is the equal of any that has been developed anywhere in the world. The reason it has grown—and continues to grow—is that it has grown naturally. You cannot build a tree. Our problem is to take our existing system and continue to make it bigger and better."

In regard to provisions for stimulating enrollment in voluntary prepayment plans, Senator Hill in part said:

"The states will be assisted in surveying the extent of protection enjoyed by their citizens and in developing methods of increasing this protection, both as to number of persons enrolled, and completeness of protection.

"The states will be encouraged to provide payroll deductions for employees of state and local governments who wish to purchase such

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CLEVELAND: J. R. Ticknor, Representative 817 Rose Bldg., Tel. Main 0446
COLUMBUS: L. G. Nelson, Representative, 2800 Indianola Ave., Tel. Lawndale 6200

protection in this manner for themselves and their dependents.

STATES ASSISTED

"The states will be assisted in the payment of subscription charges in addition to unemployment compensation benefits for such period of time as a person having such enrollment may be out of work.

"In other words, the bill will stimulate and encourage voluntary protection against the cost of the usual hospitalized illness for every person who can afford the subscription charges."

The bill is limited to care provided in a hospital or a diagnostic clinic. Senator Hill stated: "I do not believe we have sufficient medical resources—doctors, nurses, hospital, and other facilities—to provide all the care which would be called for if we immediately included such services as office calls, home care and minor illnesses."

Senator Hill summed up the health program outlook as follows: "Hospitals and health centers are being built under the Hospital Survey and Construction Act. There is now pending in the Congress legislation designed to increase our supply of well-trained doctors and nurses. As these programs go forward, we can then provide in an orderly manner for the expansion of the services made available under the bill."

An analysis of S. 1456 issued by the authors follows.

PURPOSE

To make high quality hospital and medical care available to all by

1. Providing protection to persons financially unable to pay all or part of subscription charges for prepayment of hospital and medical care.

2. Stimulating voluntary enrollment in prepayment plans for hospital and medical care emphasizing

   a. employer participation in transmission of subscription charges;

   b. enrollment in rural areas.

3. Strengthening and coordinating existing health resources.

DEFINITIONS

a. "Hospital and medical care" is defined to mean surgical, obstetrical and medical services furnished in the hospital and hospital services incident there up to 60 days in any year. It includes diagnostic and out-patient clinic services furnished in a hospital or diagnostic clinic.

b. "Hospital" includes any hospital which has an average patient stay of less than 30 days or any diagnostic clinic. The hospital or diagnostic clinic must conform to standards of maintenance and operation established by the State.

c. "Voluntary prepayment plan" may include any corporation or association furnishing protection against the cost of hospital and medical care on a voluntary prepayment basis. Only "non-profit prepayment plans" are to be concerned with furnishing protection to persons unable to pay subscription charges. But both commercial and non-profit plans may be involved in other sections of the program (see below).

ADMINISTRATION

At the **Federal level** the program would be administered by the Surgeon General. Regulations to be promulgated within six months after enactment of the Act shall include:

a. General standards of eligibility of persons unable to pay subscription charges.

b. General types of hospital and medical care to be provided.

c. General standards for participation of voluntary prepayment plan.

d. General standards for participation of non-profit prepayment plan.

e. General methods of assisting in enrollment of the population in prepayment plans by states.

A Federal Hospital and Medical Care Council of 10 persons (2 doctors, 2 hospital administrators, 2 prepayment plan executives, 4 consumer representatives) will share responsibility with the Surgeon General in developing these broad policies of the program.

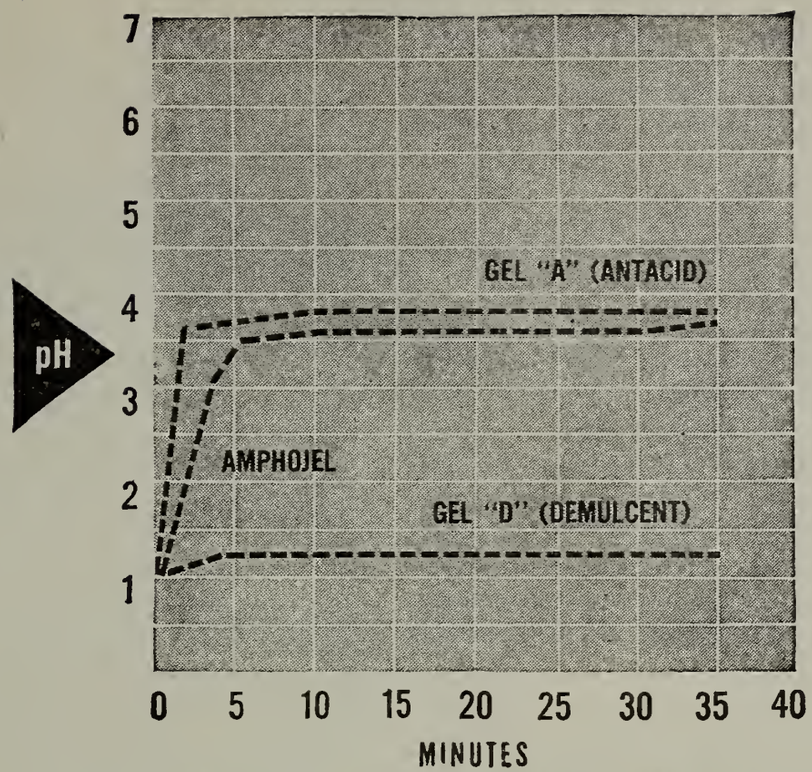
At the local level the program is to be administered by a state agency which may be the same agency now administering the Hill-Burton Hospital Survey and Construction program in the state. This agency is to have a council with representation similar to that of the Federal Hospital Care Council.

In addition, the states are to be divided into **regions** in which complete hospital and medical services are available. These regions may be already established under the surveys of the Hill-Burton Act. Within each region a Hospital and Medical Care Authority shall operate as a unit of the state agency. The Authority will be composed of persons residing within the region including representatives from as broad a segment of the population as possible. The Authority shall encourage coordination of all health facilities and services in the region and recommend means for their effective use in serving the areas.

FINANCING

Federal appropriations are authorized for such sums as may be necessary.

Federal funds are to be matched on a variable percentage by funds from within the states. The same formula is used as in the Hill-Burton Hospital Survey and Construction Act, which provides that a higher percentage of Federal funds will be available to states with lower per capita income. The practical limit of the pro-



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gram may be the amount of money which must come from within the States to match Federal funds.

The State plan must provide that the State itself will put up at least 50 per cent of the matching funds so that half or less than half of the matching percentages will come from local communities.

THE PROGRAM

Essential features of the State plans, in addition to the foregoing, are:

1. Federal funds must be used in addition to present activities and not as a substitute source of financing for things now being done.

2. Determination of eligibility for assistance shall be made in advance of the need for hospital and medical care, insofar as possible; the individual shall not be identified as a person accepting assistance at the time of receiving care; the individual shall not be provided a separate grade or classification of care because of accepting assistance.

3. Prepayment service cards will be issued to qualified persons which will entitle them to needed hospital and medical care if they are certified as unable to pay subscription charges. These cards will be issued by appropriate agencies designated by the State and will be cards of participating non-profit prepayment plans who meet standards prescribed by Federal regulations.

4. Persons able to pay subscription charges in full may be enrolled in the usual manner by the prepayment plans. But persons able to pay part or none of the subscription charge shall receive care at the expense of the State agency under this program.

5. Four surveys must be made by the State agency, and in each case, plans are to be developed for meeting needs of the State for:

a. Existing diagnostic facilities.

b. Existing facilities, services and financing for the care of mental, tubercular and chronic disease and other patients hospitalized for long periods of time.

c. Areas in the state unable to attract doctors.

d. Existing enrollment in participating voluntary prepayment plans.

6. The States and political subdivisions must provide for payroll deductions of subscription charges in voluntary prepayment plans for all employees who request such deduction.

7. The Bill also provides for payroll deductions for Federal employees who request it for subscription charges of prepayment protection.

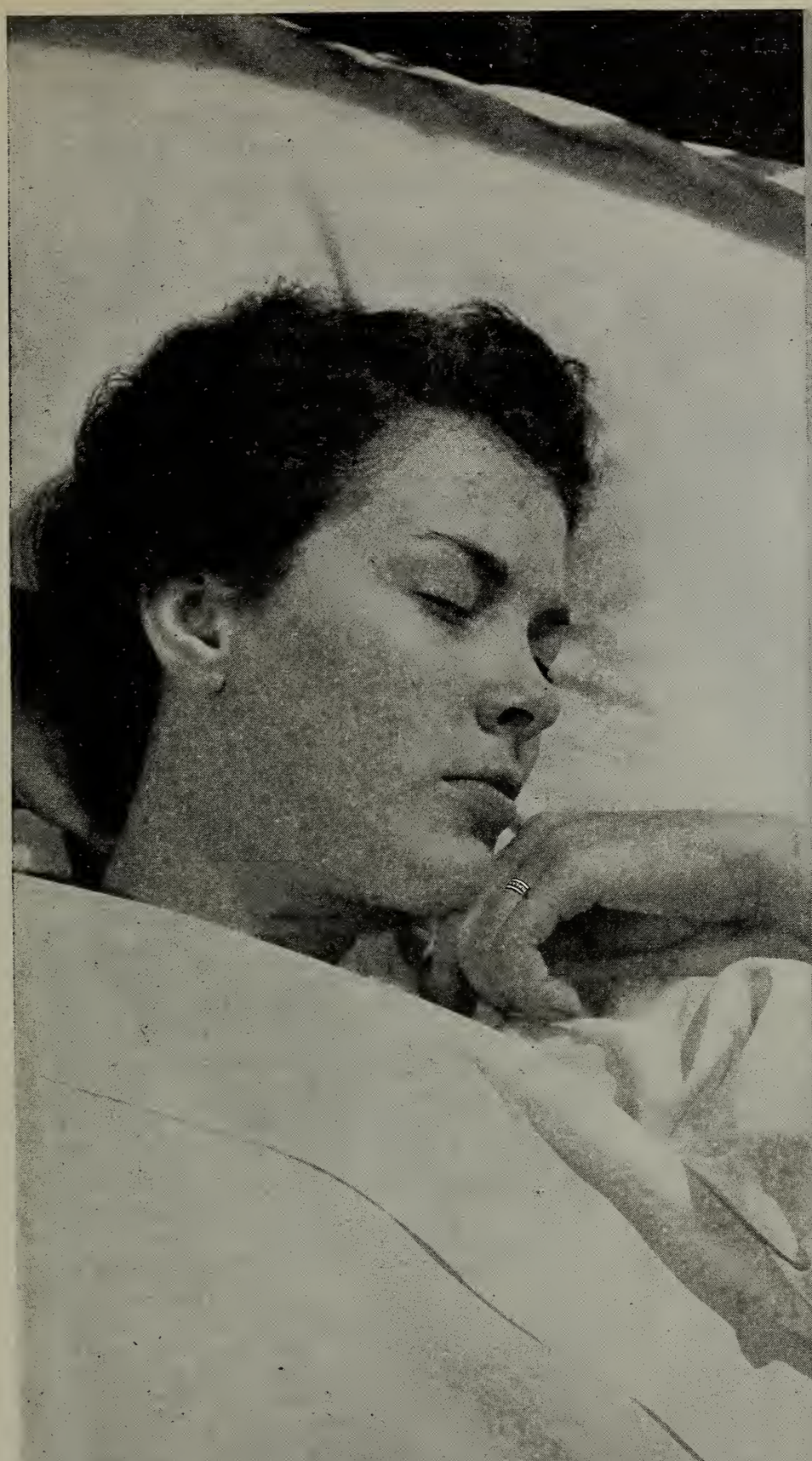
* * *

Commenting on the proposed "Voluntary Health Insurance Bill," S. 1456, *The Journal of the American Medical Association* ran the following editorial in its issue of April 9:

Elsewhere in this issue *(Journal of the A. M. A.)* appears an abstract of a bill introduced into the Senate of the United States on March 30 by Senator Lister Hill and four other senators associated with him. The bill proposes allocation of Federal funds to the individual states, so that state authorities, established in the field of medical care, may secure voluntary hospitalization and sickness insurance policies for persons unable to pay the costs of medical care either in whole or in part. On the local and state authorities is placed the responsibility for determining the need of the persons concerned in each instance. Provision is made for aiding hospitals, health centers and diagnostic institutes so that they may render necessary services to those unable to pay. The measure would thus make effective as law several of the most significant points in the twelve-point program for the extension of medical care developed by the American Medical Association. According to reports in the press, Mr. Hill was aided in the development of this legislation by conferences with the American Hospital Association, the president of the Pennsylvania State Medical Society and several other interested individuals and agencies. The measure, which has been considered by the Washington office of the American Medical Association and by the Executive Committee of the Board of Trustees, is a type of legislation that corresponds with the principles of the twelve-point program which have been urged by the American Medical Association for some years. Such legislation is in accord with the basic principles of freedom of choice of physician and hospital, and absence of interference in the personal relationship between doctor and patient. Apparently many legislators, who represent great numbers of American citizens, are aware of the importance of maintaining these principles. Several other measures in relationship to these same principles are, it is understood, to be introduced to the Congress. No doubt, public hearings will be heard on all of these measures and all of them will come before the House of Delegates at its next session, so that the House of Delegates may establish the policy of the American Medical Association on new measures concerning extension of medical care. Senator Hill has also been quoted as preferring to build on the system already prevailing rather than destroying our civilization to experiment with a new one. The measure proposed by Senator Hill apparently would require some clarification, and there should be definite assurances as to the extent of necessary regulations in making the measure, if passed, effective.

Research Society Elects

Professor Emeritus A. J. Carlson of the University of Chicago and former president of the American Association for the Advancement of Science, was re-elected president of the National Society for Medical Research at the group's annual meeting in Chicago. Dr. A. C. Ivy, head of the University of Illinois College of Medicine, was re-elected secretary and treasurer.



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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NEW STUDY ON SUPPLY AND DISTRIBUTION OF DOCTORS

A study which will provide accurate information about the supply and distribution of physicians in the United States for the first time is being made by Frank G. Dickinson, director of the Bureau of Medical Economic Research of the American Medical Association.

This is a project which may play a vital part in the current discussions with respect to the supply and demand of physicians. It is a well known fact that one of the bugs in this question is the mal-distribution of physicians. The study should provide some accurate basic material which can be used in efforts to find a solution.

Using information furnished by state and county medical societies, Dickinson has divided the nation into 757 medical service areas, somewhat similar to the trade areas that have been used in studying buying and selling habits of the population.

Because doctors and patients often cross state and county lines to give and receive medical care today, the traditional methods of computing the supply and distribution of doctors by counties and states do not provide an accurate picture. The number of persons per doctor in any county is a meaningless figure and the state is too large to be used as a medical service area.

A progress report on the study shows that every person in the United States lives in one of these 757 medical service areas and that there are doctors in each area on whom persons in the area usually depend for their medical care.

Although some persons live near the border of each medical service area and some live in counties that have no doctors, no one lives outside a medical service area.

People in each area obtain most of their medical care from doctors in that area. The average number of counties per area is four. The areas vary in shape and size and few of the boundary lines coincide with the boundaries of counties. Two hundred and twelve areas cross state lines and 545 are entirely within states.

There are 1,090 primary medical service centers, of which 87 offer every type of medical treatment and surgery. The remaining 1,003 primary centers are cities and towns which, relative to the nearby towns and villages, are primary sources of medical care. A large number of areas have two or three primary medical service centers.

The number of secondary centers cannot be tabulated until the new American Medical Directory is completed. Distance to the nearest doctor cannot be figured until these secondary centers are established.

"Now that the areas have been established, the number of people per physician in each area can be determined and the resulting physician-population ratios will provide some indication of the distribution of physicians," Dickinson said.

YES, IT COULD HAPPEN IN OHIO

To date, Ohio has not been confronted with legislation to create a compulsory sickness insurance scheme in this state. Nevertheless, it would behoove the medical profession, as well as all others who are aware of the dangers of such a system, to keep their powder dry; keep close watch on any political developments which would indicate action of this kind, for it would come as a political football, if it comes, not because of any crying need or any large demand on the part of the people.

What could happen in Ohio or any other state is indicated by the present situation in California. California doctors will face a precarious and uncertain future if S. 157, a bill which has been introduced in the California Senate, is enacted, points out an editorial in the April 9 issue of *The Journal of the American Medical Association.* The editorial said in part:

"For a third time, Governor Warren is now advocating a compulsory health insurance program for California. The program would be financed, in part, by compulsory payroll taxes, referred to as 'contributions' imposed on employers and employees.

"The existing Department of Employment and a newly created Health Service Authority would administer the act. This authority would include the director of public health as chairman, the chief executive officer of the Department of Employment, three physicians, two representatives of labor, two representatives of employers, and one dentist, the last eight members being appointed by the governor.

"An executive director of the authority would be appointed also by the governor but on nomination by the authority. A medical advisory board, a hospital service advisory board and an advisory committee on postgraduate study would be established, all of which would have no other responsibilities than giving advice.

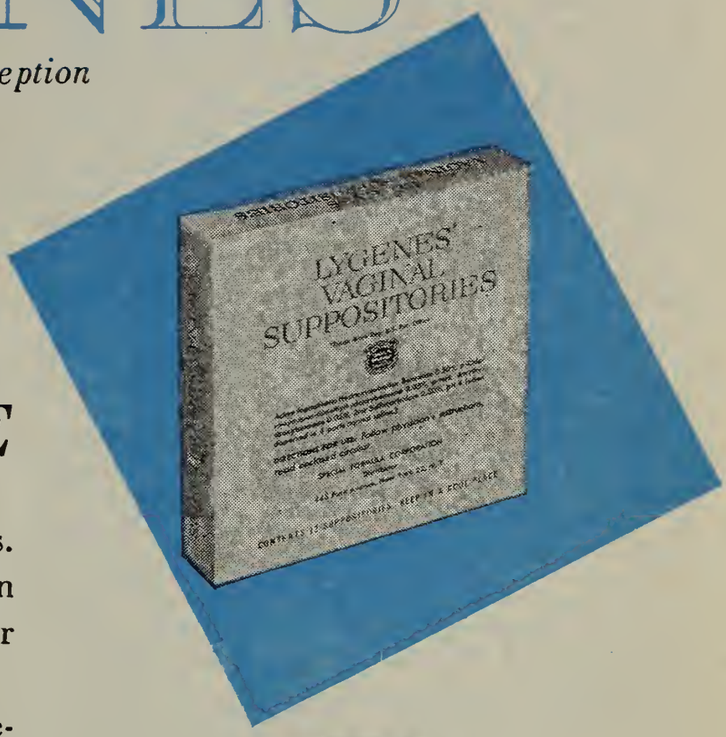
"The concluding article of the bill, Article 14,

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*Eastman, N. J. & Seibels, R. E.: J.A.M.A., 16:139, 1949.

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deals with penalties. Unprofessional conduct calling for the revocation of his license is charged against a physician who fails to disclose any 'material fact known to him to obtain any service or benefit provided under the act.'

"Each physician who participates in the program will presumably have to determine at his peril what is or is not a material fact. Failure to disclose by physicians and by others is also declared to be a misdemeanor, as is also willful violation of any rule or regulation promulgated or published to effectuate the program.

"Scattered throughout the 20 pages of this bill are innumerable statements in which the authority is authorized by regulation to impose requirements. Apparently any express and clear provision for hearings on these regulations or for their publication in any definite manner is not included; yet a violation of any one of these would constitute a criminal offense.

"This is the application of the methods of the 'police state' at their worst to dominate the practice of medicine politically.

"While a beneficiary may utilize more expensive hospital accommodations than those supplied under the bill, by paying the difference in cost, if a beneficiary and a physician mutually agree that the fee for medical services set by the authority is inadequate and if an additional fee is accepted by the physician, except in the case of a beneficiary entitled to reimbursement only, the license of the physician is made subject to revocation.

"California physicians would face a precarious and uncertain future if this preposterous bill were to be enacted into law."

SCHOOL HEALTH SURVEY IN ALL COUNTIES

The secretary of each county medical society in Ohio and other states will soon receive in the mail a questionnaire on school health services in his community. The American Medical Association in cooperation with the U. S. Office of Education is making a study of school health services through its Bureau of Health Education. The survey is a preliminary step in efforts designed to bring about improvement of school health programs within the framework of the private practice of medicine. For this reason, it is most important that each local medical society complete and return the questionnaire.

The U. S. Office of Education in Washington will concurrently query the schools. Two different questionnaires which supplement and reinforce each other and contain no duplicate questions are being used. The information requested is needed to determine present strengths and weaknesses in school health services, to indicate needs, and to point up action for the future. The questionnaire has been tested prior to printing and all unnecessary questions eliminated.

Here's hoping all local secretaries will cooperate to the utmost and return the questionnaire to the A. M. A. with complete information as promptly as possible.

CHECKING UP ON COMMUNITY HEALTH PROGRESS

The Chamber of Commerce of the United States, the Ohio Chamber of Commerce, Cincinnati Chamber of Commerce, Pennsylvania Chamber of Commerce and the Indiana Chamber of Commerce are to be congratulated on the community health institute they sponsored on April 7 at Cincinnati.

The theme of the meeting, "Has Your Community Kept Pace with the Nation's Health Progress" was handled in excellent fashion by the speakers who were assembled from all over the nation. Unfortunately the attendance did not keep space with the quality of the program.

Among the speakers was Dr. James R. Miller, Hartford, Conn., a member of the Board of Trustees of the American Medical Association, who emphasized the importance and value of community health councils.

President of the U. S. Chamber, Earl O. Shreve, as well as the other speakers, urged that greater emphasis be placed on community interest and action in health matters, if for no other reason than to prove that radical national legislation is unnecessary. Compulsory sickness insurance schemes were condemned. Examples of excellent health programs carried on in their communities were discussed by several of the speakers representing such widespread areas as Williamsport, Pa., Atlanta, Ga., and San Francisco, Calif.

More such meetings should be held with the business and professional people represented. It would be feasible to hold them on a county basis—an idea for any county medical society to think about.

BITTER MEDICINE BEING BREWED FOR MR. FARMER

Dear Doctor:

No doubt you have some patients and friends among the farmers of Ohio. It is suggested that the next time you see them you urge them to take a careful look-see at the new medicine which U. S. Secretary of Agriculture Brannan has compounded to keep the farmer healthy, wealthy and wise (politically).

As we understand it, the idea is to have dear old Uncle Sam set a guaranteed price on farm products. Then, he would let the market prices for commodities rise or fall with the law of supply and demand but step in with a dole to farmers to meet differences between the guaranteed and market prices. Sounds great, doesn't it?

But, wait—there's something bitter in the concoction. First, where's the dole coming from? Naturally, out of higher taxes which the farmer among others will pay. Then, too, there will have to be a nice little margin to take

care of the costs of bureaucracy in running this business.

That's not all. Uncle Sam will have to enforce controls and rules. He'll have to decide what farmers can plant; how they can sell; what benefits they can receive; how big a farm each can run, etc, etc.

While giving your farmer friends this bit of information—if they don't know it already—tip them off that the gang which has dished up this pill for them is the one which is compounding a socialized capsule to "cure" the medical and health services of the country.

Since it appears Mr. Farmer and his family doctor are both on the sucker list of the Washington "medicine men," you might suggest to him that it's about time for them to join hands, take a good look at what's going on, find out who's trying to do what to whom, and then do something about it.

IT'S "FREE" IF YOU PAY FOR IT

We see by the papers that Sir Stafford Cripps, British chancellor of the exchequer, has informed Britishers that they can't expect a reduction of taxes from their present lofty perch so long as they are willing to bless cradle-to-the-grave social security. Moreover, he has informed the folks that the bill can't be paid for entirely by soaking the rich and that the little man is now going to have to pay for his "free" medical services and other doles.

Speaking bluntly, Sir Stafford laid it on the line with this observation: "When I hear people speaking of reducing taxation, and at the same time, see the costs of social services rising rapidly, in response very often to the demands of the same people, I sometimes rather wonder whether they appreciate to the full the old adage that 'we cannot have our cake and eat it!' "

Those on this side of the Atlantic who think that the British s. s. program is so grand and would like to see a counterpart put into effect here would do well to ponder Sir Stafford's comment—and that goes for the so-called champions of the "little fellow" who are trying to sell a bill of goods by falsely inferring that "it's free."

THERE IS NO POINT IN TALKING TO OURSELVES

Discussing a business program of action to check socialism, "Design for Freedom," sponsored by the Ohio Chamber of Commerce, Mr. C. I. Weaver, president of that organization, made this pungent statement:

"We must tell the story to those who need to know the truth. There is no point in talking to ourselves."

The recommendation is certainly applicable to the medical profession and its campaign to enlighten the people about the drive to submerge medicine in the welfare-state. It won't do physicians much good to talk to themselves. They will have to get out and tell the people—not necessarily the people who are against socialism in general but more especially those who for one reason or another might be gullible.

Until each County Medical Society in Ohio has an active speakers bureau and competent speakers for telling the story at work, the first job to be done will be unfinished.

A. A. P. S. SHOULD FOLLOW EXAMPLE OF N. P. C.

Elsewhere in this issue will be found an announcement from the National Physicians Committee stating that it is being dissolved and that all of its activities had been terminated as of April 1, 1949. The announcement will please many, especially those who have felt that the American Medical Association always has been the proper agency to speak nationally for the medical profession. The action of the N. P. C. was a wise one.

This should set an example for the American Association of Physicians and Surgeons, another so-called "independent organization" whose activities are likewise confusing to both the public and the medical profession. Also it is not doing a single thing which the A. M. A. and its component state and county medical societies are not doing.

Here again the criticism is not directed at a single individual connected with the A. A. P. S. but at the absence of any sound reason for the existence of the organization. Those who are devoting their energies to this organization could do far more good if they would use their talent and energy—which they do have—in active support of the new, constructive, positive program launched by the real parent organization, the American Medical Association.

ANTIVIVISECTIONISTS CREATE SMOKE WITHOUT FIRE

The adage that many signers of petitions don't even know what they are signing has come to light again—this time in regard to the antivivisectionists.

The Saturday Evening Post at a recent reckoning had received petitions signed by more than 5,000 persons taking issue with its article on vivisection. On four occasions personnel connected with the *Post* staff sent questionnaires to samplings of the signers asking if they had read the article they criticized. Not one reply was received. The *Post*, however, did receive a scattering of individual comments both for and against the article, so reports the *Bulletin of the National Society for Medical Research.*

Ohio Medical Indemnity . . .

Report to Board Shows That More Than 500,000 Persons Are Covered By O. S. M. A. Voluntary Medical Care Plan; Board Officers Elected

THE Ohio Doctors' Plan for voluntary medical care insurance has expanded within little more than three years until it now has an enrollment of more than 500,000 persons covered, it was reported at a meeting of the Board of Directors of Ohio Medical Indemnity, Inc., held in Columbus on April 6.

"The operation has been a successful one and there is every reason to be proud of being the fifth largest Blue Shield Plan in the country," Mr. Charles H. Coghlan, executive vice-president of the company, reported to the Board.

Mr. Coghlan reported that more than two-thirds of claims paid are on services rendered to wives and children of subscribers.

Referring to a breakdown of claims paid during 1948, Mr. Coghlan pointed out that more than 18 per cent of claims paid was in the field of obstetrics and another 14 per cent (almost 25 per cent of amount paid) was in the field of gynecology. Another 20 per cent of claims paid was for tonsillectomies (principally on children).

The average working man is convinced, Mr. Coghlan asserted, that a voluntary medical care insurance which protects his family as well as himself is worth while.

A breakdown of claims paid during 1948, showing percentages of amount paid and percentages of number of claims in each category, is shown in the following table:

Type of Service	% of Amount Paid	% of Claims
Gynecology	24.9	14.4
Deliveries	15.0	17.2
Miscarriages	0.4	1.3
Appendectomies	12.4	7.4
Hernias	5.3	3.8
Cholecystectomies	3.8	1.8
All Other Abdominal Surgery	4.1	2.3
T & A	9.7	20.2
General Surgery	7.3	10.3
Fractures	4.5	7.1
Other Orthopedic	1.8	2.2
Proctology	3.5	4.2
Urology	2.7	3.3
Ophthalmology	1.3	1.3
Neuro-Surgery	1.3	0.8
Nose & Throat (Ex. T & A)	1.1	1.5
Thoracic Surgery	0.6	0.6
Otology	0.3	0.3

During the year 1948, enrollment was started in 16 additional counties by concluding agreements with Youngstown and Lima Blue Cross Plans. This makes a total of seven Blue Cross Plans now cooperating with Ohio Medical.

The subscribers contract was again broadened in April and November of 1948. The latter extension of benefits was most important as the six-month waiting period on tonsillectomies was eliminated and more important still, certain surgery performed in the doctor's office was added as a benefit. The addition of this office surgery filled an evident gap in the coverage, particularly in rural areas where the patient and doctor were located some distance from hospital beds.

Probably the greatest demand encountered to date by Medical Indemnity is from the individual who requests the opportunity to enroll and is not eligible under group enrollment. These individuals fall into two classes as follows: (1) Farmers, self-employed and the small merchants having less than five employees; and (2) individuals employed in an establishment having more than five employees and who have been, for some reason or other, unable to enroll as a group subscriber. Plans to provide coverage for such persons are now under consideration.

Total payments to subscribers during 1948 amounted to $1,804,519, bringing the total amount paid out during the life of the plan to more than $3,200,000.

Officers of the company elected at the Board meeting are: Dr. L. Howard Schriver, Cincinnati, president; Dr. Carll S. Mundy, Toledo, vice-president; Mr. Charles H. Coghlan, Columbus, executive vice-president; Mr. Charles S. Nelson, Columbus, secretary-treasurer; Mr. Frank W. Van Holte, Columbus, assistant treasurer; and Mr. Wayne E. Stitcher, Toledo, general counsel.

Members of the Board of Directors, elected on April 6, are: Dr. Schriver; Dr. Robert C. Rothenberg, Cincinnati; Mr. James E. Stuart, Cincinnati; Dr. R. K. Finley, Dayton; Dr. Mundy; Dr. A. A. Brindley, Toledo; Mr. Waldo M. Bowman, Toledo; Dr. Edgar P. McNamee, Cleveland; Dr. William M. Skipp, Youngstown; Mr. D. A. Endres, Youngstown; Dr. C. C. Sherburne, Columbus; Dr. H. M. Clodfelter, Columbus; Mr. E. C. Pohlman, Columbus; Mr. Clair E. Fultz, Columbus; Dr. Robert T. Allison, Jr., Akron; Mr. Harold W. Slabaugh, Akron; Dr. J. Craig Bowman, Upper Sandusky; Dr. Carl A. Lincke, Carrollton; Dr. John Marshall, Findlay; Mr. Henry W. Harter, Canton, and Mr. H. J. Winkeljohn, Celina.

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• Philip Morris is the *only* cigarette proved definitely and measurably less irritating!** Perhaps you too will find it worth while to suggest *"Change to* PHILIP MORRIS."... by far the wisest choice for *everyone* who smokes.



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***May we send you copies of these published studies:*

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

Do You Know? . . .

Delegates to the 52nd annual convention of the Ohio Federation of Women's Clubs held at Toledo April 7-8, voted to oppose any compulsory health insurance plan. The 925 delegates represent 75,000 Ohio clubwomen.

* * *

Dr. Bruce K. Wiseman, chairman of the Department of Medicine, Ohio State University College of Medicine, gave the Vincent Park Williams Memorial Lecture at a meeting of the Jackson County Medical Society, March 22, at Kansas City. His subject was "The Blood Platelet and Thrombocytopenic Purpura."

* * *

Dr. Clarence E. Hufford, Toledo, Chairman of the Committee on Cancer of the Ohio State Medical Association, participated in the American Medical Association's weekly N. B. C. radio program, "Your Health Today," Saturday afternoon, April 2. Dr. Hufford spoke on the educational program of his committee. Approximately 100 stations are on the nation-wide hookup for "Your Health Today," each Saturday afternoon at 4 o'clock E. S. T.

* * *

Western Reserve University School of Medicine has received a gift of $100,000 from the Louis D. Beaumont Foundation, Cleveland, with no restriction placed upon the use of the fund in the activities of the school. According to Dr. Joseph T. Wearn, Dean of the school, the money will be used to pay better salaries to faculty members.

* * *

The Greene County Medical Society has endorsed a memorial fund being created in honor of Dr. David Taylor, Yellow Springs, a past-president of the society who died March 26.

* * *

A check for $1,525,167 from 10,000 General Motors automobile dealers throughout the country to be used for cancer and other medical research, recently was presented to the Sloan-Kettering Institute for Cancer Research, New York.

* * *

The American Medical Association reports that the median age for 199,475 physicians last year was 44.4 years compared to 45.8 for 175,146 physicians in 1940.

* * *

Dr. Robert A. Kehoe, Cincinnati, added to his record and that of the University of Cincinnati when he received the Knudsen Award of the American Association of Industrial Physicians and Surgeons at its annual convention in Detroit. Established in 1938 through the late General William Knudsen of General Motors Corporation, the award is made for each year's outstanding work in the field of industrial medicine. Dr. Kehoe is a member of the Committee on Industrial Health of the Ohio State Medical Association.

* * *

Dr. Norvin C. Kiefer of the U. S. Public Health Service, and formerly in private practice at Geneva, Ohio, has been named director of the medical division of the National Security Resources Board.

* * *

Dr. Paul W. Schafer, a graduate of the Ohio State University College of Medicine, 1939, has been named chairman of the department of surgery of the University of Kansas School of Medicine, Kansas City, Mo. Associate professor of surgery at Kansas since last July, Dr. Schafer previously was an instructor in surgery at the University of Chicago clinics.

* * *

Dr. Max M. Peet, professor of surgery at the University of Michigan Medical School and chief of the neurosurgical division of the University Hospital at Ann Arbor since 1918, died March 25, aged 63, of heart attack.

* * *

A bill to license chiropractors in the State of New York came within two votes of passage by the State Senate during the closing days of the New York State Legislature. With 29 votes required for adoption, the bill received 27 "Ayes" and 26 "Noes."

* * *

Dr. George M. Curtis, professor of surgery, Ohio State University College of Medicine, Columbus, spoke on "The Management of Hyperthyroidism," at a meeting of the Wayne County Medical Society, Detroit, March 21.

* * *

"Political, Socio-economic and Economic Problems Facing the Medical Profession," was the topic discussed by Dr. L. Howard Schriver, Cincinnati, at a luncheon session during the Third Annual Postgraduate Clinical Institute sponsored by the Michigan State Medical Society, March 23-25, at Detroit.

* * *

Congressman Walter B. Huber, Akron, a Democrat, and representative of the 14th Ohio Congressional District, has introduced H. R. 1512 in the House of Representatives, authorizing the appointment of chiropractors in the medical department of the Veterans Administration.

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✓	No Patient Discomfort

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National Physicians Committee Ends Activities and Is Being Liquidated

Following is an official announcement issued by the Board of Trustees of the National Physicians Committee stating that all of its activities were discontinued as of April 1, 1949, and that the organization is being liquidated:

"Ten years ago, a group of officers and fellows of the American Medical Association realized that the American Medical Association was not as active in certain functions as was deemed necessary, some of which seemed at that time inappropriate for the American Medical Association to perform. As a result, the National Physicians Committee for the Extension of Medical Service was created and has worked during these intervening years within the policies established by the House of Delegates of the American Medical Association.

"Several times during those years, the House of Delegates has expressed confidence in the work of this organization.

"Two years ago, a Committee of the House of delegates reported that 'the American Medical Association should and must do its own public relations work.'

"In December, 1948, the House of Delegates took action to create a new agency to carry on public relations activities and to further the extension of medical care. This new agency has been created and is functioning. The program as planned and now being carried on by the American Medical Association represents the fulfillment of the objectives for which the National Physicians Committee was created and toward which it has been working.

"Its aims having been accomplished, the Board of Trustees of the National Physicians Committee met in Chicago on April 10, 1949, and voted (1) to approve the action of its Management Committee in authorizing cessation of all activities as of April 1, 1949, and (2) to liquidate the affairs of the National Physicians Committee in an orderly manner.

"It planned further to hold its next meeting in Atlantic City in June, 1949, and at that time to consider further action looking toward dissolution of the organization.

"During its ten years of activity, the National Physicians Committee has brought about the formation of forty-seven state committees of physicians and forty-six state committees of dentists, in addition to other local organizations, that have functioned vigorously and well. The Board of Trustees now suggests to the physicians making up the personnel of these state committees that they offer their services to the new American Medical Association agency."

(Signed) EDWARD H. CARY, M. D., *Chairman*,
N. P. C. Board of Trustees.

Planning for Older People To Be Discussed at Symposium

A symposium sponsored by the Ohio Citizens' Council for Health and Welfare, in cooperation with the Division of Mental Hygiene, Ohio Department of Public Welfare, and the Ohio Mental Hygiene Association, Inc., will be held in Campbell Hall, Ohio State University, Columbus, on Thursday and Friday, May 13 and 14.

The subject for the symposium will be "Community and State Planning for Older People in Ohio."

At 11 a. m. on Thursday, Dr. Edward L. Steiglitz, Washington, D. C., will speak on the subject, "The Challenge of Longevity."

From 2 to 5 p. m., a panel discussion will be held on the subject, "Specific Needs and Areas for Service." At 7:45 p. m., Thursday, speakers will discuss the subjects, "Economic Security for Older People," and "An Opportunity and a Responsibility."

On Friday morning beginning at 9:30, four workshops will be held on the following subjects: "Social Adjustment," "Health for Older People," "Mental Health in the Older Years," and "Recreation Activities for Older People."

The general topic for Friday afternoon, 2 to 4:30 p. m., will be "Steps Forward in Planning for Older People."

Dr. Calvin L. Baker, commissioner of the Division of Mental Hygiene, Ohio Department of Welfare, will lead the discussion on the workshop on "Mental Health in the Older Years," Friday morning.

Grass Roots Conference Scheduled In Atlantic City June 5

The Fifth National Conference of County Medical Society Officers will be held in Hotel Traymore, Atlantic City, on Sunday, June 5, the day before the opening of the Annual Session of the American Medical Society. All physicians are invited to attend. County medical society officers are especially urged to attend.

The program for the June meeting is designed to answer some of the principal problems confronting county medical societies. It will include practical demonstrations of special activities, together with exhibits and examples.

Each subject will be presented by a panel composed of individuals thoroughly familiar with the subject under discussion. Some of the principal topics to be discussed are: "Is Your Society Prepared To Care for Emergency Calls?"; "What Do Members Know About Your Society?"; "Is Your Speakers' Bureau Active?"; and "Does Your Society Have a Plan for Caring for the Indigent?"

This "Grass Roots" conference is sponsored by the Board of Trustees of the A. M. A. The meeting is scheduled to begin at 9 a. m.

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ROUNDUP ON PREPAID MEDICAL CARE PLANS

With a fourth quarter gain of 1,057,274 members, the largest quarterly growth in the history of the prepayment medical care movement, Blue Shield national headquarters announced recently that 1948 enrollment had totalled 10,370,819 persons. The million-member gain represented a growth of 11.35 per cent of the fourth quarter of 1948.

Contributing to this phenomenal growth was the enrollment of Ford Motor Company employees, totalling approximately 250,000 persons, the majority of which were enrolled in Michigan Medical Service.

Blue Shield in Michigan continues to be the largest Plan in the nation with a December 31 enrollment of 1,311,811, followed closely by Blue Shield in New York City with 1,128,967 persons enrolled.

Although still relatively modest in size, Pennsylvania's Blue Shield Plan experienced one of the most rapid enrollment gains during 1948, increasing its membership 171 per cent for a new total of 353,643.

Blue Shield Plans in Indiana, New Jersey, and Kansas City, Missouri, went over the 200,000 member mark during the latter part of 1948.

Delaware still leads all other Plans in the percentage of population protected, having enrolled approximately 49 per cent of the state's population. Michigan follows with 21 per cent of the population enrolled.

Blue Shield growth for 1948 showed a 43.39 per cent net gain over 1947, with an addition of 3,138,628 members during the year.

* * *

Blue Cross and Blue Shield membership is now being offered to 14,000 employees of the Tennessee Valley Authority in five southern states, with authority granted for payroll deduction in the collection of monthly dues.

Although an independent authority, T. V. A. is a government owned corporation and is classified as a Federal agency, establishing announcement of payroll deduction privileges by Harry L. Case, T. V. A. personnel director, as a significant precedent in the enrollment of Federal employees.

Blue Cross and Blue Shield coverage will be available to T. V. A. employees in Alabama, North Carolina, and Mississippi. Blue Cross only will be offered in Tennessee and Kentucky, due to the absence of a Blue Shield Plan in these two states at the present time.

* * *

Individual subscribers to Blue Cross in Rochester, N. Y., are now being given an opportunity to become members of Blue Shield, according to a recent announcement by Dr. Maurice A. Barnard, president of Blue Shield.

Originally enrolled through a group, many Blue Cross subscribers transfer to an individual contract and pay their dues directly to the Plan upon termination of their employment where the group was formed. Such non-group members frequently total more than one fourth of the enrollment in the average Blue Cross Plan.

Wherever Blue Cross membership is required before a person may subscribe to the affiliated Blue Shield Plan, these direct payment members have not been eligible due to group enrollment requirements.

Blue Shield in Rochester is one of the first Plans to offer membership to Blue Cross non-group subscribers.

An earlier experiment of this type was made in Kansas City a year ago, and repeated again this summer, with nearly 40 per cent of the eligibles signing up for Blue Shield.

Proctologists To Celebrate 50th Anniversary in Columbus

The American Proctologic Society will celebrate its Fiftieth Anniversary when it meets May 31 to June 4 at the Deshler-Wallick Hotel in Columbus. The Society was founded in that city on June 6, 1899, by fourteen proctologists from various sections of the country.

Approximately twenty members of the Section of Proctology of the Royal Society of Medicine will attend. Guest speakers from the British group who are presenting papers on the program will be: Mr. A. Lawrence Abel; Mr. W. B. Gabriel; Mr. C. Naunton Morgan; Dr. Cuthbert Dukes; Mr. R. W. Raven; Mr. A. Dickson Wright and Mr. E. C. B. Butler.

Other speakers appearing on the program by invitation will be Dr. C. W. Mayo and Dr. John S. Lundy of Rochester, Minnesota, and Dr. Lyon Appleby of Vancouver, B. C.

The early date in June was chosen to allow the members and British guests ample time to attend the 1949 session of the A. M. A. at Atlantic City.

Admission to the annual meeting is limited to members and such guests as are sponsored by them. Secretary of the Society is Dr. W. W. Green of Toledo.

COMING MEEINGS

American Medical Association, Annual Session, Atlantic City, June 6-10.

American Goiter Association, Madison, Wis., May 26-28, 1949.

American Roentgen Ray Society, Cincinnati, week of Oct. 3.

International and Fourth American Congress on Obstetrics and Gynecology, New York City, May 14-19.

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Buckeye News Notes . . .

Alliance—Dr. Douglass S. King, Dr. William E. Elliott and Dr. George M. Wilcoxon took part in a discussion on "Socialized Medicine" before the "Opinion Exchange," sponsored by the speech department of Mount Union College.

Cleveland—The Women's Medical Society at the April 13 meeting had as guest speaker Dr. Hymer L. Friedell who spoke on "The Youth of Radio-Active Isotopes in Medicine."

Cleveland—Dr. Claude S. Beck spoke before the City Club Forum on the subject, "Surgery of the Heart—Today and in the Future."

Cleveland—Dr. Charles A. Barnes, Bradford, Pa., was named director of medicine at Doctors' Hospital.

Columbus—Dr. Robert M. Zollinger was selected by the Editorial Advisory Board of the American Medical Association to serve as a member of the Committee on Surgery.

Columbus—Dr. Thomas E. Rardin was re-elected president of the Metropolitan Health Council at a meeting on March 16.

Cincinnati—Dr. Benjamin Hoyer spoke in behalf of the Taft Memorial Association at a meeting of the Mt. Auburn Community Center.

Circleville—Dr. V. D. Kerns discussed the importance of diet at a meeting of the Trinity Lutheran Church Brotherhood.

Gallipolis—Dr. Leo C. Bean was honored at a surprise birthday party by the local Rotary Club. He was first president of the club 21 years ago.

Gallipolis—Dr. Paul C. Foster was elected president of the local Rotary Club.

Kenton—Dr. Raymond G. Schutte was named honor citizen of the month of January in Hardin County by "The Best Is Yet to Come," a gathering sponsored by the Kenton Fortnightly Club.

Lancaster—Dr. Floyd R. Town of Lansing, Mich., has been appointed as the city's first full-time health commissioner. He succeeds Dr. C. B. Snider who served for 25 years as part-time commissioner.

Marion—Dr. Warren C. Sawyer of White Oaks discussed "The Problems of Later Life" at a meeting of the Rotary Club.

Massillon—Dr. Roy H. Clunk conducted a vocational guidance session in the Washington High School.

New Philadelphia—Dr. Thomas F. McGough resigned as Tuscarawas County health commissioner to accept a similar position at Alexandria, Va.

Springfield—Dr. A. Richard Kent addressed members and guests of the Clark County Mental Health Society at its annual meeting on the subject, "Our Town."

Steubenville—Dr. R. J. Foster, New Philadelphia, Seventh District Councilor, spoke before a public gathering on the subject of "Socialized Medicine." The meeting was sponsored by the Woman's Auxiliary to the Jefferson County Medical Society.

Strasburg—Dr. E. C. Davis, Jr., of Dover, addressed members of the St. John's Evangelical and Reformed Church Forum recently on the subject, "Compulsory National Health Insurance."

Toledo—Dr. Edward J. McCormick, member of the Board of Trustees of the A. M. A., and Dr. Carll S. Mundy, Fourth District Councilor, took part in a forum discussion before the National Council of Jewish Women.

Troy—Dr. Harry E. Shilling discussed "Heart Disease and What It Means to You," at a meeting of the Lions Club.

Troy—Dr. Brent A. Welch, Miami County health commissioner, spoke before the Lions Club on the subject of cancer.

Upper Sandusky—Dr. Joseph A. Muenzer, Toledo, was guest speaker at the annual Communion Breakfast for men of St. Peter's Catholic Parish.

Van Wert—Dr. Floyd A. McCammon addressed a recent meeting of the Kiwanis on the subject, "Socialized Medicine."

Warren—Dr. E. A. Ockuly, Toledo, spoke before a public meeting sponsored by the Zonta Club and the Women's Professional group.

Wauseon—Dr. Bernard Steinberg of Toledo addressed a recent meeting of the Fulton Cancer Society.

Woodfield—Dr. R. H. Latta of Graysville was named president of the Monroe County Health Board for a term of five years.

Youngstown—Dr. W. H. Bunn addressed the Youngstown Shrine Club on the subject of the heart, in connection with the observance of National Heart Week.

Youngstown—Dr. B. I. Firestone spoke over Station WFMJ in behalf of the American Heart Association campaign.

Youngstown—Dr. Harold J. Reese spoke over Station WFMJ on the subject of cancer.

Zanesville—Dr. D. G. Caudy has arranged for eight weekly broadcasts over Station WHIZ. The prepared broadcasts are in the field of public health education and are sponsored by the City Health Department.

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In Memoriam . . .

Burt Thomas Church, M. D., North Hollywood, Calif.; University of Nebraska College of Medicine, 1923; aged 51; died March 15; former member of the Ohio State Medical Association through 1944 and a Fellow of the American Medical Association; president of the Lake County Medical Society in 1934 and its secretary-treasurer, 1932-33. Dr. Church practiced in Painesville and Fairport until he moved to California in 1944. He was a member of the Masonic Lodge and the Kiwanis Club. Surviving are his widow, a son and a daughter.

Wesley Paul Damerow, M. D., Mariemont; Rush Medical College, University of Chicago, 1928; aged 49; died March 20; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Damerow practiced in the Cincinnati area from 1929 to 1942, when he entered the Army Medical Corps. After the war he made his residence in Mariemont and maintained an office in Milford. Surviving are his widow, a son, two daughters and a sister.

Rolland Edward Gardner, M. D., Reynoldsburg; University of Louisville School of Medicine, 1929; aged 47; died March 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Gardner practiced medicine in Reynoldsburg for approximately 12 years. He held membership in several Masonic Orders and was a past master of his local lodge. He also was a member of the Methodist Church. Surviving are his wife, a daughter, his parents and a brother.

Ralph English Garnhart, M. D., Milan; Ohio Medical University, Columbus, 1904; aged 73; died April 7; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Erie County Medical Society in 1934. Dr. Garnhart retired from active practice about five years ago after nearly 40 years of practice in Milan. Surviving are his widow, a daughter and two sisters.

Glenn Ira Goodrich, M. D., Dover; Ohio Medical University, Columbus, 1903; aged 70; died March 20; member of the Ohio State Medical Association and the American Medical Association; president of the Tuscarawas County Medical Society, 1939-40, and vice-president in 1938. Dr. Goodrich practiced medicine in Dover and vicinity for 46 years, and was one of the founders of the Union Hospital there. He was past commander of the local Knights of Pythias Lodge, a member of the Modern Woodmen and the Methodist Church, and a former member of the local Rotary Club. Two sons survive.

Charles Lee Harding, M. D., Bellevue; Eclectic Medical College, Cincinnati, 1896; aged 74; died April 1; former member of the Ohio State Medical Association and the American Medical Association through 1947; Dr. Harding practiced his profession in Bellevue from 1896 until illness forced his retirement in 1947. In addition to his practice he was active in civic and fraternal affairs of the community; was a member of the Methodist Church and of several Masonic Orders; was a past president of the local Kiwanis Club and served as lieutenant governor of Kiwanis division. A veteran of World War I, he was past commander of the local American Legion Post. Surviving are his widow and a daughter.

James Frank Mayne, M. D., Ashland; University of Wooster Medical Department, Cleveland, 1889; aged 89; died March 26; former member of the Ohio State Medical Association and the American Medical Association through 1929. Dr. Mayne practiced in Norwalk for many years before his retirement.

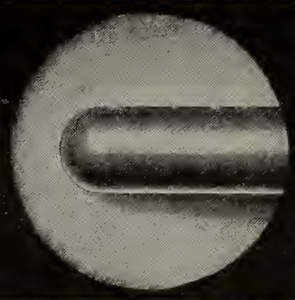
Frank Murphy, M. D., Beverly Hills, Calif.; Pulte Medical College, Cincinnati, 1894; aged 78; died early in March. Dr. Murphy formerly was health commissioner for Dayton and Montgomery County. He moved to California about 1916. A daughter and a sister survive.

Clarence Virgil Porterfield, M. D., St. Clairsville; Ohio State University College of Medicine, 1913; aged 60; died March 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Porterfield practiced in Neffs before moving to St. Clairsville where he continued his professional career. He was a member of the Presbyterian Church and was president of the Belmont County Board of Health. Surviving are his widow, two sons including Dr. Robert A. Porterfield, also of St. Clairsville, and a brother.

Homer Dudley Roads, M. D., Cincinnati; University of Cincinnati College of Medicine, 1923; aged 51; died March 21; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American College of Surgeons. Dr. Roads had been in practice in Cleveland for many years before going to Cincinnati for postgraduate study. Surviving are his widow, two sons and two daughters.

Eva C. Roloson, M. D., Delaware; Eclectic Medical College, Cincinnati, 1890; aged 87; died March 18. Dr. Roloson practiced medicine, principally in Delaware for more than 50 years.

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Thomas Hugh Spyker, M. D., Fort Dix, N. J.; Ohio State University College of Medicine, 1946; aged 26; died March 27. A former resident of Columbus, Dr. Spyker was nearing completion of a tour of duty as Captain in the Medical Corps. He was a member of the Methodist Church and of Delta Upsilon Fraternity and Nu Sigma Medical Fraternity. Surviving are his widow, a son, his parents and three brothers, including Dr. Mitchell A. Spyker, formerly of Columbus.

David Taylor, M. D., Yellow Springs; Rush Medical College, University of Chicago, 1934; aged 50; died March 26; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Greene County Medical Society in 1939 and 1948. Dr. Taylor practiced his profession in Yellow Springs since completion of his medical education except for the time spent with the Army Medical Corps during the war. After serving in the European Theater he was discharged with the rank of lieutenant-colonel. He was a member of the Methodist Church, several Masonic Orders and the American Legion. Surviving are his widow, two sons, two brothers and three sisters.

Archibald Moltz Wilkins, M. D., Delta; Toledo Medical College, 1898; aged 75; died March 29; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Fulton County Medical Society from 1944 through 1947 and its vice-president from 1934 through 1943. Dr. Wilkins practiced medicine in Delta over a period of 51 years. He was a veteran of the Spanish American War, Philippine Insurrection, Mexican Revolution and World War I. He was a member of the Seventh Day Adventist Church, the Rotary Club and was a past commander of the local American Legion post. Surviving are his widow, a son and a sister.

Samuel Lutz Zurmehly, M. D., Rushsylvania; Miami Medical College, Cincinnati, 1890; aged 88; died April 7; former member of the Ohio State Medical Association and the American Medical Association through 1936; vice-president of the Logan County Medical Society in 1929. Dr. Zurmehly practiced in Bridgeport, Ala., before going to Rushsylvania in 1912. During World War I he served with the Army Medical Corps. He held memberships in the Methodist Church, the Masonic Lodge and the Woodmen of the World. Surviving are his widow and two daughters.

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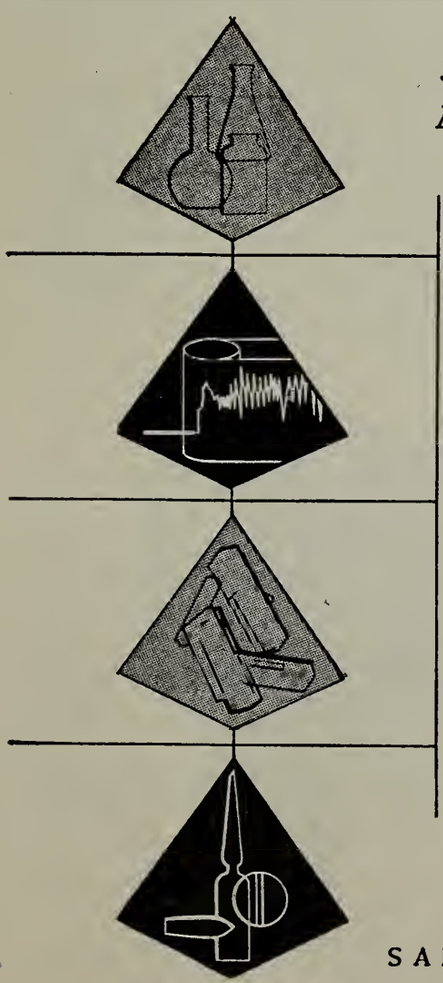
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Golfers' Tournament . . .

Springfield Country Club Entices Doctor Golfers of Ohio To Take Part in Annual Affair June 16; Banquet and Awarding To Climax Day

An active committee of 18 golfers from Springfield headed by Dr. Joseph H. Rinehart, announced that final arrangements have been completed to hold this year's tournament of the Ohio State Medical Golfers Association at the beautiful Springfield Country Club.

Working on instructions as agreed upon by the membership at last year's Annual Meeting, the committee secured the ample facilities of this private club for Thursday, June 16. Members will recall that a Wednesday or Thursday date early in the season was thought to be more convenient for the medical golfers of Ohio. Dr. Rinehart in conjunction with the officers, settled on the above date because it would not be in conflict with the A. M. A. annual session in Atlantic City and would be after the school term ends—assuring a sufficient number of caddies.

EXCELLENT FACILITIES

The Springfield Country Club Course is well known as a tournament course and will prove an excellent battleground on which to determine the winners of the many events and the accompanying prizes, the committee assured. The course is in fine condition, is not too hilly, well trapped, fast rolling greens and 6,505 yards of fairways and greens to tempt any golfer. Arrangements have been made for the members of O. S. M. G. A., (plus doctors who will become members this year) to play warm-up rounds on Wednesday, the day before the tournament.

Locker facilities will be ample to take care of the visiting golfing doctors. It might be mentioned that the Springfield Country Club has a nineteenth hole, a handicap which had to be overcome in a dry environment at the 1948 tournament. The committee has arranged for a substantial luncheon for the hard playing golfers at noon and a sirloin steak dinner for the festive banquet which will be followed with entertainment.

MAKE RESERVATIONS EARLY

Dr. Sam Zuker, President of O. S. M. G. A., urges the doctors of Ohio who play golf to set aside June 16 as a day of recreation and good-fellowship with doctors from all over Ohio. In order that the officers and local committee at Springfield can make this year's tournament increasingly better you are urged to complete the Reservation Blank below and mail at once to the secretary.

The Shawnee Hotel in Springfield, has been designated as headquarters for those members who wish accommodations for either Wednesday or Thursday nights. Hotel reservations should be made by June 6.

INVITATIONS FOR NEXT YEAR

Because the O. S. M. G. A. has decided to hold its tournament and Annual Meeting in different locations throughout the State, the chairman will call for invitations for the 1950 meeting during the business session following the banquet. If the members in your community would like to entertain this organization you may present your invitation at that time.

RESERVATION BLANK

for 1949 Annual Meeting

OHIO STATE MEDICAL GOLFERS' ASSOCIATION

To the Secretary:

I am going to attend the Golf Tournament on June 16 at Springfield, Ohio. I have enclosed a check to cover green fees, luncheon, banquet and prizes ($10.00).

I would also like room reservations for Wednesday night, June 15 ....., Thursday night, June 16 ..... Number of persons ..... Twin ..... Double .....

Please check: New Member..... Old Timer..... (If new member, please add $2.00 initiation fee to above amount).

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Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

Members of the Butler County Medical Society and the Butler County Bar Association held a joint meeting at which Dr. Herbert P. Lyle, Hamilton County coroner, discussed the coroner's relationship to doctors and lawyers.

CLINTON

Dr. C. E. Richards of Dayton spoke on "Infections of the Urinary Tract" at the April 5 meeting of the Clinton County Medical Society in Wilmington.

HAMILTON

Dr. George W. Thorn, Harvard University Medical School, spoke on the subject, "Clinical Studies on Pituitary-Adrenal Relationships," at the April 5 meeting of the Academy of Medicine of Cincinnati. Two nominating committees presented lists of candidates at the April 19 meeting to be voted on at the annual election in May.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

The scientific meeting of the Clark County Medical Society was held on March 21 in Springfield. Speaker for the occasion was Dr. Lawrence A. Pomeroy, Western Reserve University School of Medicine, who spoke on "Results in the Treatment of Carcinoma of the Cervix."

MIAMI

Dr. Melvin Oosting, Dayton, presented a study on "Tumors of the Kidney," at the April 1 meeting of the Miami County Medical Society at the Stouder Hospital, Troy. The monthly Bulletin of the Society contained an appeal for all members to forward their $25 A. M. A. educational program assessments and make the county's record 100 per cent. The Society has started a new series of programs over Station WPTW, Piqua, entitled "Time Out." It is scheduled at 10:45 a. m. on Saturdays.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

ALLEN

Dr. Bruce K. Wiseman, Columbus, spoke before the Academy of Medicine of Lima and Allen County on March 15 on the subject, "Anemia; Cause, Recognition and Rational Therapy."

MERCER

Members of the Auglaize County Medical Society were guests of the Mercer County Medical Society at a dinner meeting held in Celina on April 3. Speaker for the occasion was Dr. Phillips K. Champion of Dayton who spoke on "Newer Concepts of the Toxemias of Pregnancy."

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

DEFIANCE

At the March 9 meeting of the Defiance County Medical Society, it was voted to secure recordings from the A. M. A. for use on the society-sponsored program. Records on V. D. control were approved as part of the radio program. The cancer control program was discussed and Dr. John U. Fauster, Jr., was named to contact the local Cancer Society in regard to a cancer clinic.

LUCAS

"Pancreatic Disease From the Standpoint of Acute and Chronic Inflammation and Malignancy" was discussed by Dr. M. S. Lopusniak, University of Pennsylvania, at the March 11 meeting of the Toledo Academy of Medicine.

SANDUSKY

Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association, discussed "Socialized Medicine" at a joint meeting of the Sandusky County Medical Society and the Woman's Auxiliary in Fremont on March 16. Members of the Auxiliary entertained with a pot luck dinner.

WOOD

The Wood County Medical Society met in regular session at the Everglades restaurant, Perrysburg, March 17. Dr. Paul Orr presided. The paper of the evening was given by Dr. Edward L. Burns of Toledo on "Diagnosis of Common Anemias in Adults." Dr. Burns, formerly assistant Professor of Pathology at Louisiana State University, gave an account of the clinical manifestations of anemia as presented to the general practitioner. He stressed the need of expert laboratory diagnosis for confirmation and differentiation of the various types as indication for the specific therapy. Lantern slides supplemented the text.

Dr. Burns' presentation was followed by a lively question period.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

The following features were on the April program by sections of the Academy of Medicine of Cleveland:

Clinical and Pathological Section, April 1—"Pulmonary Circulation in Man," Dr. H. A. Zimmerman; "Coronary Circulation in Patients With Cor Pulmonale and Severe Anemias," Dr. A. F. Young and Dr. Zimmerman.

Pediatric Section, April 6—"Experiences in the Care of Prematures," Dr. Stewart H. Clifford, Boston.

Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine—"Liver Glycogen as an Indicator of Intermediary Metabolism of Isotopically Labeled Carbohydrates and Fatty Acids," by Victor Lober; "The Use of Radioactive Carbon to Study the Intermediate Compounds Involved in the Biosynthesis of Nucleic Acids," G. Robert Greenberg, Ph. D., and "A Study of the Interconversion of Glycine and Serine in the Rat, and the Role of Formic Acid in this Reaction," Warwick Sakami, Ph. D.

Internal Medicine Section, April 13—"The Clinical Application of Cardiac Catheterization," Dr. W. H. Pritchard and Dr. H. K. Hellerstein.

Industrial Medicine and Orthopedic Section, April 20—"Fractures of the Os Calcis," Dr. James A. Dickson; "Spontaneous Median Neuropathy," Dr. George S. Phalen; "Beryllium Poisoning," Dr. H. S. Van Ordstrand, and "Posterior Dislocation of the Shoulder," Dr. J. I. Kendrick.

Obstetrical and Gynecological Section, April 26—"Post Spinal Headache in Obstetrics at City Hospital," Dr. Paul Hanahan and Dr. T. E. Redding, and "Study of Hysterectomies at Huron Road Hospital," Dr. J. J. Woodworth.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

COLUMBIANA

Dr. Paul A. Davis, Akron, Sixth District Councilor, discussed socialized medicine at the March 15 meeting of the Columbiana County Medical Society in East Liverpool. A scientific discussion of "Surgical Aspects of the Gall Bladder," was presented by Dr. Walter S. Nettrour of Pittsburgh. Members went on record as favoring a centralized tuberculosis treatment center.

PORTAGE

Dr. Guy H. Williams, Jr., Cleveland, spoke on "Some Aspects of Psychosomatic Medicine" at the April 7 meeting of the Portage County Medical Society, Robinson Memorial Hospital in Kent.

SUMMIT

Dr. Perk Lee Davis, Jefferson Medical College, of Philadelphia, spoke on the subject, "Reflections on Advances in Cancer Research and Therapy," at the April 5 meeting of the Summit County Medical Society in Akron.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

TUSCARAWAS

A joint meeting of the Coshocton County Medical Society and the Tuscarawas County Medical Society was held at Wainwright on March 10. Dr. Francis C. Boyer, Canton, spoke on newer methods of relieving pain.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

ATHENS

Dr. Benjamin C. Houghton, Columbus, spoke before the March 8 meeting of the Athens County Medical Society in Nelsonville on the subject, "The Recent Advances in the Therapy of Hematologic Dyscrasias."

GUERNSEY

The Guernsey County Medical Society had its regular meeting on March 17 at the Hotel Berwick in Cambridge. Dr. Reo Swan presided over the meeting in the absence of Dr. William L. Denny. Members discussed cancer clinics and decided to begin them on the evening of March 22. Dr. B. S. Gillespie presented a case history on pulmonary tuberculosis illustrated with X-rays.

MUSKINGUM

The Muskingum County Academy of Medicine and the Woman's Auxiliary held a dinner and cabaret party at the Edgewater Beach on March 5. An open discussion on socialized medicine was held at the April 6 meeting of the Academy in Zanesville.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

LAWRENCE

Mr. Harry M. Stultz, field director for the Blue Cross plan, explained phases of the plan at the March 29 meeting of the Lawrence County Medical Society at Coal Grove.

SCIOTO

Mrs. Margaret Henry, Bureau of Aid to the Aged, Scioto County, spoke on "Health Care

Allowance for the Needy Aged in Ohio," at the April 11 meeting of the Hempstead Academy of Medicine at the General Hospital in Portsmouth.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FAYETTE

At the April 1 meeting of the Fayette County Medical Society Dr. Marvin Roszmann reviewed discussions held at the County Society Officers' Conference of the Ohio State Medical Association held in Columbus on March 20. The subject of equipment and a staff for the new hospital also was discussed.

FRANKLIN

At the April 4 meeting of the Columbus Academy of Medicine, Dr. Leon Schiff, University of Cincinnati College of Medicine, spoke on "The Differential Diagnosis of Jaundice."

At the April 18 meeting, Dr. David A. Boyd, Jr., Rochester, Minn., spoke on "The Psychological Language of the Organs."

MADISON

A joint meeting of the Madison County Medical Society and the Woman's Auxiliary was held late in March with dinner at the London Country Club.

MORROW

Mr. Curtis Inscho, Columbus architect, met with the Morrow County Medical Society on April 5 and discussed plans for the new hospital.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

Four members of the Ohio State University College of Medicine faculty took part in the Lorain County Medical Society Postgraduate Day on April 6 at the Spring Valley Country Club, Elyria. More than 70 physicians attended the symposium.

Dr. Allan C. Barnes of the department of obstetrics and gynecology spoke on the subject, "Analgesia and Anesthesia in Obstetrics."

Dr. Stanley O. Hoerr, department of surgery, discussed "The Modern Methods in Handling Minor Traumatic Surgery."

Dr. C. Joseph DeLor of the department of medicine spoke on "Medical Aspects of Liver Disease."

Dr. Norman O. Rothermich, department of medicine, presented a talk on "Medical Aspects of the Aching Back."

Following the banquet, Dr. Barnes spoke on the subject of "Office Gynecology."

RICHLAND

A combined meeting of the Richland County Medical Society and the active staff of Mansfield General Hospital was held at the hospital on March 17. A buffet dinner was served, after which a business meeting was conducted by the president, Dr. R. R. Crawford. The speaker on this occasion was Dr. Robert W. Heinle, Western Reserve University, who discussed, "The Newer Drugs in the Treatment of the Lymphoma Group of Diseases."

Woman's Auxiliary . . .

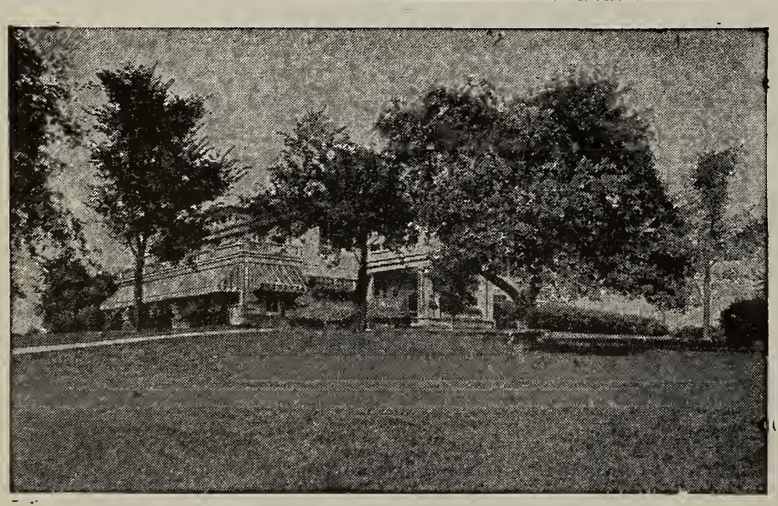
By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

NATIONAL CONVENTION

Last call for reservations for the Twenty-Sixth Annual Convention of the Woman's Auxiliary to the American Medical Association, which will be held at Haddon Hall, Atlantic City, N. J., June 6 to 10. Requests for reservations should be sent at once to Dr. Robert A. Bradley, chairman, subcommittee on hotels, 16 Central Pier, Atlantic City, N. J.

ALLEN

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County Academy of Medicine held a guest tea in the home of Mrs. C. H. Leech. Mrs. V. H. Hay, auxiliary president, extended greetings and Mrs. M. M. Sondheimer, introduced the speakers. Mrs. J. R. Tillotson had as her topic "Socialized Medicine" and Dr. Nathan Kalb, of the Northwest Guidance Center, explained the work of the center and also conducted a questionnaire.

CLARK

The Woman's Auxiliary to the Clark County Medical Society met on March 25 at Kiefer Junior High School. Mr. Samuel Whitman, Executive Director of the Cleveland Mental Hygiene Association, was guest speaker. His subject was "Children's Part in Peace." A film "Feeling of Rejection" was shown. The program was sponsored by the Clark County Medical Society, its Auxiliary, and the Mental Hygiene Society.

On April 21 for Career Day of the Auxiliary the Nurse Recruitment and Fellowship Committee was in charge of the nursing section at the Y. W. C. A. For the workshop session the film "R. N. Serving All Mankind" was shown. A panel discussion followed. Follow-up letters have been sent to the 108 girls who indicated an interest in nursing as a profession in all Clark County High Schools. Current magazines are being collected for the student nurses and all unused tickets to civic functions are being distributed to the student nurses.

ERIE

On March 14 the Woman's Auxiliary to the Erie County Medical Society met at the Business Women's Club for a luncheon meeting. Mrs. H. W. Lehrer introduced the guest speaker, Miss Alice Chaffin, a Huron school teacher. Miss Chaffin discussed the "Development of the Total Personality of the Child." A short business meeting was held during which Mrs. William Fenker, president of the group, presided. The Tuesday morning programs over the local radio station are proving most interesting and informative.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine observed guest day at its meeting on March 21 in the Little Theater at the Columbus Gallery of Fine Arts. The East High School Spiritual Choir directed by Miriam Holycross Summerford presented a program of music. Mr. Wilbur E. Crist of the Capital University Conservatory of Music was guest speaker. Mrs. Clyde Dawson, chairman, Mrs. John Q. Brown and Mrs. Truman Fletcher, co-chairmen, were in charge of arrangements for tea which followed the program.

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by this auxiliary, is the provision of occupational and recreational therapy supplies in Franklin County. However, new projects will be added as the need appears. The Nurse Recruitment program has been growing in interest and service. The Franklin County Student Nurse Recruitment Committee is composed of the five directors of the Columbus Schools of nursing, representation from District No. 12, Nurses' Association and the following members of the Franklin County Auxiliary, Mrs. Luther W. Adams, Chairman, Mrs. L. W. Rohr, co-chairman, Mrs. Harry A. Minthorne, Mrs. Paul W. Palmer and Mrs. George Peters.

The committee's objective is to stimulate interest in nursing as a career. The program which has been made available to all high schools in Columbus and Franklin County is being used in general assemblies for vocational guidance purposes and for health classes. The program consists of talks by two local student nurses. A film "Nursing" is shown. The need for a nurse recruitment film that could be used by movie theaters was satisfied with the completion of a special trailer "Helen Hayes Inaugurates the Hospital Careers Campaign." Miss Hayes donated her time and talent for the film. Through the cooperation of the Ohio Independent Theater Owners Association this trailer was shown in several of the local theaters.

Posters have been placed in schools and waiting rooms. A bibliography in the nursing field has been prepared, names and addresses of schools of nursing for male students and Negroes have also been provided. This project will continue as long as the need remains.

MONTGOMERY

The Woman's Auxiliary to the Montgomery County Medical Society met on March 15 at the Art Institute. After the secretary's report was read the treasurer reported a balance of $508.25 in the bank with the membership of 184 in good standing. Mrs. R. C. Markey, project chairman, reported seven women stuffed envelopes for the Mental Hygiene Association. She also read letters of thanks from the nursing schools of the three hospitals to whom each had been given $50.00 for recreational activities for the student nurses.

The program chairman reported the next meeting would be held at the Fidelity Building and the speaker's topic would be "New Look for the Home." New officers for this group are: President, Mrs. John Groff; president-elect, Mrs. Robert Zipf; vice-president, Mrs. C. E. Numma; corresponding secretary, Mrs. Ed. Sacks; recording secretary, Mrs. R. C. Barth-

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The standard fee is $150 per month. There have been funds donated which can be used to help a few children whose parents cannot pay the full fee. The Camp is a non-profit organization under the direction of a Board of Trustees composed of prominent citizens of Cleveland and a director appointed by them. The Camp is staffed with a resident, licensed physician, nurses and dietitians. The medical director is E. Perry McCullagh, M. D.

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PICKAWAY

Members of the Woman's Auxiliary to the Pickaway County Medical Society were hostesses to their husbands for a dinner March 23 in Pickaway Country Club. An informal social evening followed the dinner. In the group were Dr. and Mrs. Lloyd Jonnes, Dr. and Mrs. Walter F. Heine, Dr. and Mrs. E. L. Montgomery, Dr. and Mrs. Edwin S. Shane and Dr. and Mrs. J. M. Hedges of Circleville and Dr. and Mrs. Richard Hedges, Ashville.

RICHLAND

One of the most interesting meetings of the season for members of the Woman's Auxiliary to the Richland County Medical Society was held in April with 27 members and two guests present. A round table discussion featured the program using the theme "Uncle Sam in Medicine." Mrs. Ralph Wharton led the discussion. Mrs. R. R. Crawford reported on "Agencies for Medical Aid and Education in Mansfield."

ROSS

Mrs. F. W. Nusbaum was named president of the Woman's Auxiliary to the Ross County Academy of Medicine at the election which followed the group's monthly dinner April 7 at Allyn's Dining Room. Other new officers include Mrs. W. E. Kramer, vice-president; Mrs. Paul Shepherd, secretary; Mrs. R. L. Counts, treasurer; and Mrs. Glen Nisley, board member.

Mrs. E. H. Artman, retiring president had charge of the business meeting. She appointed a committee to administer the student nurses' loan fund for the coming year. Announcement was made of a special program to be given by the auxiliary some time in April to interest Chillicothe and Ross County high school girls in a nursing career. Miss Margaret Hunsicker of Columbus will be the speaker and a movie, "Girls in White" will be shown.

SANDUSKY

Mrs. Robert Fox, Green Springs, was elected president of the Woman's Auxiliary to the Sandusky County Medical Association February 16 at a meeting in the Memorial Hospital Nurses' Home. Also named to assist her were Mrs. A. F. Schultz, president-elect; Mrs. Lloyd E. Drossell, Woodville, secretary, and Mrs. E. L. Koons, treasurer. A report was given by Mrs. Schultz from the County Welfare Council Meeting in January on poliomyelitis. The dessert card party was given by this group on February 15. Cards were played at twenty-six tables and prizes given at each.

The members of this auxiliary entertained the Sandusky County Medical Association and



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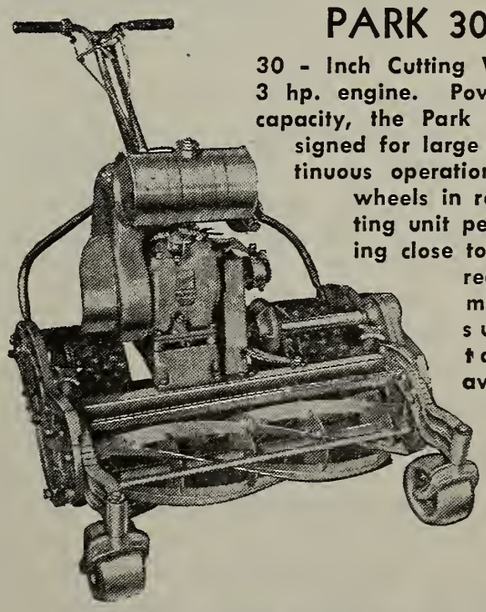
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guests at a potluck dinner in the Nurses Home March 16. Following the dinner, Dr. Shoemaker, president of the Medical Society, introduced the speaker of the evening, Dr. A. A. Brindley, Toledo, President of the State Medical Association. He spoke on compulsory health insurance. A round table discussion followed. Out-of-town guests were Dr. and Mrs. A. A. Brindley, Toledo, Dr. Cyrus Wood, Port Clinton, and Mrs. Wood, director of the Fourth District, Mr. and Mrs. Jack Hahn and many guests from Bellevue and Clyde.

SUMMIT

At the April meeting of the Woman's Auxiliary to the Summit County Medical Society the following officers were elected for the coming year. The incoming president is Mrs. F. M. McDonald; president-elect, Mrs. C. C. Nohe; vice-president, Mrs. E. W. Canffield, recording-secretary, Mrs. T. V. Gerlinger; treasurer, Mrs. R. E. Williams; and corresponding-secretary, Mrs. William M. Keller.

TUSCARAWAS

The Woman's Auxiliary to the Tuscarawas County Medical Society met at the home of Mrs. Burrell Russell, New Philadelphia. After a dessert course was served by the hostess, the business meeting was conducted by the president, Mrs. M. W. Everhard. A film on cancer distributed by the local cancer society was enjoyed by those present. The film "The Doctor Speaks His Mind" gave an intelligent approach to the cancer problem.

WYANDOT

A year ago, when the Woman's Auxiliary to the Wyandot County Medical Society was a fledgling in the State organization, it aspired to make some contribution toward the Wyandot County Memorial Hospital. Last Nov. 11 it sponsored a Minstrel show given at the Sycamore High School auditorium by Sycamore talent. The show was a decided success and the proceeds for the auxiliary amounted to $600. To this was added the proceeds of a benefit bridge party given previously and this enabled the secretary-treasurer to write a check for $1,000 as a donation to the new hospital.

So the auxiliary felt it had good news for the State president, Mrs. E. Benjamin Gillette, when she was a guest at a luncheon on March 7. Mrs. Gillette spoke to the group on the aims and projects of the auxiliary stressing the need to give financial aid to prospective student nurses, and emphasizing the responsibility of the auxiliary in bringing facts before the public on such subjects as public health and compulsory health insurance. Mrs. Harold K. Mouser was a guest and related the various activities of the Marion County Auxiliary.

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Fourth District General Practitioners Hold Third Meeting

The Fourth Councilor District Chapter of the American Academy of General Practice held its third meeting in the Wittenberg dining room in Columbus Grove on March 24 as guests of the Putnam County Medical Society.

The group was honored to have present among others the following: Dr. Earl W. Burgner, Akron, secretary of the Ohio Academy of General Practice; Dr. Henry W. Lehrer, Sandusky, treasurer of the state organization; Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District, Ohio State Medical Association, and a director of the Ohio Academy of General Practice; Dr. Roscoe H. Snyder, Toledo, and Dr. Ross M. Knoble, Sandusky, directors of the Ohio Academy of General Practice.

Guest speaker for the occasion was Dr. Joseph Lindner, Cincinnati, president of the Ohio Academy. Dr. Lindner gave a history of the instigation and formation of both the American and the Ohio Academies of General Practice, and gave a vivid description of the first annual meeting of the American Academy in Cincinnati March 9-11.

The 50 doctors present from the Third and Fourth Councilor Districts made this meeting a success in many particulars.

Cuyahoga General Practitioners Elect Officers

Dr. Herbert W. Salter, Cleveland, was elected president of the Cuyahoga County Chapter of the Ohio Academy of General Practice at the first meeting held at Doctors Hospital, Cleveland, in February. Other officers are Dr. Hugh Amos, vice-president, and Dr. John J. Folin, secretary-treasurer, both of Cleveland.

Approximately 50 members were present for the opening meeting. Those present expressed confidence that the organization is fulfilling a need for the general practitioners. Members were urged to invite qualified acquaintances to join the organization.

Cook County Courses

The Cook County Graduate School of Medicine of Chicago has arranged two courses that will be of special interest to some of the members of the Ohio State Medical Association. A Two Weeks' Intensive Personal Course in the "Diagnosis and Treatment of Congenital Malformations of the Heart" will be offered by Benjamin M. Gasul, M.D., starting Monday, June 13. A Two Weeks' Intensive Personal Course in "Cerebral Palsy" will be offered by M. A. Perlstein, M.D., starting Monday, August 1. These physicians are members of the Attending Staff of the Cook County Hospital.

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New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since March 1, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ALLEN COUNTY
John W. Burke, Lima
Nathan Kalb, Lima

CLARK COUNTY
John E. Burnett, Jr., Springfield
Wm. K. Lehmann, Springfield

CUYAHOGA COUNTY
Carington H. Arnold, Jr. Cleveland
Frank J. Calo, Cleveland
George R. Hamilton, Cleveland
David C. Humphrey, Cleveland
William S. Jordan, Jr., Cleveland
S. R. LaTona, Cleveland
Augustine J. Raitano, Cleveland
Benjamin Root, Cleveland
Norman J. Rosenberg, Cleveland
Maurice D. Sachs, Cleveland
Royden Sawyer, Cleveland
Abraham J. Segal, Cleveland
Leo H. Simoson, Cleveland
Alfred M. Taylor, Cleveland
Russell Weisman, Jr., c/o P. M.,San Francisco, California

FRANKLIN COUNTY
John W. DeVore, Columbus
Frederick C. Finke, Columbus
Ivan S. Gilbert, Columbus
Gabriel C. Heller, Columbus
Edward C. Lawless, Columbus
Robert H. Magnuson, Columbus
Chester R. Markwood, Columbus
Robert J. Priest, Columbus
Robert E. Slemmer, Columbus
Wm. P. Smith, Jr., Columbus

GREENE COUNTY
Charles M. Buhrman, Dayton
Floyd G. Niswander, Yellow Springs

HAMILTON COUNTY
John Edward Allen, Cincinnati
James A. Helmsworth, Cincinnati
Joseph H. Jones, Cincinnati
Marvin McClellan, Cincinnati
Joseph R. Rich, Cincinnati
David H. Ross, Cincinnati
Edmund H. Schweitzer, Cincinnati

LUCAS COUNTY
Joseph C. Gallagher, Toledo
Charles F. Jones, Jr., Toledo
John D. Pattison, Jr., Toledo
Frank S. Skopek, Toledo
Oral H. Stone, Toledo

MAHONING COUNTY
William J. Flynn, Youngstown
Robert J. Heaver, Youngstown
Raymond J. Scheetz, Youngstown

MONTGOMERY COUNTY
Robert J. Bechsted, Dayton
Ray E. Burns, Dayton
James Gilboy, Jr., Dayton

PREBLE COUNTY
A. L. Ross, West Alexandria

PUTNAM COUNTY
Joseph J. McHugh, Ottawa

RICHLAND COUNTY
Alvin Bales, Mansfield

SCIOTO COUNTY
Alden B. Oakes, Portsmouth

STARK COUNTY
Joseph F. Lambright, Alliance

SUMMIT COUNTY
William M. Keller, Akron

TRUMBULL COUNTY
Anthony Lapolla, Warren

WAYNE COUNTY
Cornelius A. McGrew, Rittman

WOOD COUNTY
Francis J. Nemcik, Bloomdale
Frank W. Taylor, Arlington

Railway Surgeons

The Sixty-First Annual Meeting of the American Association of Railway Surgeons will be held at the Drake Hotel, Chicago, on Thursday, June 30, through Saturday morning, July 2.

The scientific program will be given from 10:00 to 12:30 on each of the three mornings, and from 2:00 to 4:30 on the first two afternoons. The annual dinner will be held at the Drake Hotel on Friday evening, July 1, 1949. Room reservations may be made at the Drake Hotel or at the nearby Knickerbocker Hotel.



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New Type of Narcotic Order Form Being Used

A new type of official narcotic order form is now being furnished upon request to physicians and others authorized to dispense narcotics, according to officials of the Bureau of Narcotics Columbus office. The new form went into use on April 1.

Registrants may continue to use order forms of the 1936 series until their present supply is exhausted or until the Treasury Department issues an order invalidating them.

The size and format of the order forms have been materially changed. The new Form 679 is about half the size of the old and provides spaces for ordering only five items, instead of 10 as formerly.

The new books each contain 10 sets of order forms, as heretofore. Each set, however consists of three copies, an original, triplicate and duplicate, with interleaved carbons. The old forms included only an original and duplicate. When a registrant makes out the order form he should remove the original and triplicate as a unit with the intervening carbon and send them as a unit to the vendor. The vendee is required to keep the duplicate for two years. The vendor (in Ohio) will enter in the appropriate spaces on both copies the date and manner of filling and at the end of the month will send the triplicate copy to the Narcotic District Supervisor in Detroit, Mich.

Since all forms are interspaced with carbons, registrants are advised to insert a sheet of cardboard behind the form being filled so that subsequent forms will not be spoiled.

As soon as the new forms have substantially replaced the old ones in actual use, the periodic reports of excessive purchases (Form N63) will no longer be required. Notice will be given when these may be discontinued.

American College of Physicians Elects Six Ohio Doctors

Announcement was made at the Annual Convocation of the American College of Physicians March 30 in New York of the election of six Ohio physicians to fellowship in the College.

To be eligible for fellowship in the College, a physician must have been graduated from an approved medical school, served three years as an associate in the College, and if engaged in practice, his professional activity must be limited to internal medicine.

Ohio physicians thus honored included: Dr. Frank T. Moore, Akron; Dr. Clark P. Pritchett, Columbus; Dr. Howard S. Van Ordstrand, Shaker Heights; Dr. Richard W. Vilter, Cincinnati; Dr. J. Lester Kobacker, Toledo; and Dr. C. Joseph DeLor, Columbus.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting June 20, July 25, Aug. 22. Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting June 6, July 11, Aug. 8. Surgical Anatomy & Clinical Surgery, two weeks, starting May 16, June 20, July 25. Surgery of Colon & Rectum, one week, starting June 13, Sept. 12. Esophageal Surgery, one week, starting June 13. Thoracic Surgery, one week, starting June 20. Breast & Thyroid Surgery, one week, starting June 27. Fractures & Traumatic Surgery, two weeks, starting June 13, Oct. 3.

GYNECOLOGY—Intensive Course, two weeks, starting June 20, Sept. 26. Vaginal Approach to Pelvic Surgery, one week, starting May 16, June 13, Sept. 19.

OBSTETRICS—Intensive Course, two weeks, starting May 16, Sept. 12.

MEDICINE—Intensive General Course, two weeks, starting June 13, Oct. 3. Electrocardiography & Heart Disease, two weeks, starting July 18. Gastroenterology, two weeks, starting June 27. Personal Course in Gastroscopy, two weeks, starting May 16, June 13.

PEDIATRICS—Diagnosis & Treatment of Congenital Malformations of Heart, two weeks, starting June 13. Personal Course in Cerebral Palsy, two weeks, starting Aug. 1.

DERMATOLOGY—Formal Course, two weeks, starting June 13. Informal Clinical Course every two weeks.

CYSTOSOCOPY—10-Day Practical Course every 2 wks.

UROLOGY—Intensive Course, two weeks, starting Sept. 26.

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Results of research show only about 20% of cases suitable for suction sockets. Results also show that close cooperation with doctors is necessary. Hanger is continuing research toward the amputee's great hope, and will keep the medical profession informed of its progress.

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Preventive Medicine and Public Health Board Approved

The American Board of Preventive Medicine and Public Health, Inc., was approved by the Advisory Board for Medical Specialists and by the Council on Medical Education and Hospitals of the American Medical Association at their meeting on February 6. The new board, therefore, is prepared to accept applications for examination for certification in this specialty.

The requirements for certification include general qualifications, such as moral and ethical standing in the profession, adequate training in medicine and internship in an approved hospital, and licensure to practice medicine in the United States.

Eligibility for examination also requires that the new applicant have special training and experience in preventive medicine and public health of at least six years following internship. This must include special academic training, or its equivalent, and field training or residency meeting the standards set up by the Board.

The by-laws authorize a Founders Group made up of practitioners of preventive medicine and public health who have attained unquestioned eminence as indicated by academic appointments at the level of professor or associate professor of preventive medicine and public health, or who have held positions of eminence and responsibility for a period of not less than 10 years in this field.

Academy of Neurology

Recent announcement was made of the establishment of the American Academy of Neurology. Active membership is open to every physician who has been certified in neurology or in both neurology and psychiatry. Junior membership is available to physicians presently engaged in postgraduate studies in neurology or who are awaiting certification in neurology. In addition there is an associate membership for those who are not certified but whose interests are in fields related to neurology.

The first business meeting was held in Chicago in June, 1948. The first scientific meeting will be held at French Lick Springs Hotel, French Lick Springs, Ind., June 1-3. Communications should be addressed to Dr. Joe R. Brown, secretary-treasurer, 19 Millard Hall, University of Minnesota, Minneapolis, 14.

Activities of the Editor

Dr. Jonathan Forman, Editor of *The Journal*, recently addressed a conservation forum at Montgomery, Ala., sponsored by the local Chamber of Commerce. Among other activities in which Dr. Forman engaged are the following:

He held a thirty-minute conversation over Station WCOL in Columbus with Louis Bromfield, writer and farmer.

He attended the mid-year meeting of the Board of Directors of Friends of the Land, of which he is a member.

From March 7 through 10, he was on active duty in Washington, D. C., as a consultant to the Secretary of Agriculture. Other members of the National Forest Board of Review who were in Washington with him are President R. R. Renne of Montana State College and Professor G. B. MacDonald, Iowa State College. While in Washington he spent three evenings attending meetings of the North American Wild Life Conference. On the fourth day in the national capital, members of the Board had luncheon with Secretary of Agriculture Charles Brannon and Senator Clinton Anderson, where the group discussed matters of policy in forestry.

Dr. Forman spoke before a community mass meeting at Marietta, sponsored by the Advertising Club of the Chamber of Commerce and the local chapter of Friends of the Land.

Dr. Forman assumed office as president of the American College of Allergists at its annual meeting in Chicago, April 14-17. He was elected at the annual meeting last year in New York.







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The Physician's Bookshelf

By Jonathan Forman, M.D.

Campbell's Operative Orthopedics, edited by J. S. Speed, M. D., and Hugh Smith, M. D., ($30.00. *C. V. Mosby Company, St. Louis, Missouri)* has several distinguished contributors. It lives up to its previous reception and its stated ambition "to impart pertinent orthopedic information in the light of our present knowledge by compiling previous and contemporary operative orthopedic technics infiltrated with personal suggestions, variations and our own original technic."

How To Be Healthy in Hot Climates, by Eleanor T. Calverly, M. D., ($3.00. *Thomas Y. Crowell Company, New York City)* has been written from the experience of missionaries to help others who will follow them. All done with the best of medical consultation.

The Shame of the States, by Albert Deutsch, ($3.00. *Harcourt, Brace and Company, New York City)* measures our civilization by the way government treats its insane. It is one of the few things coming from this pink pencil that may do some good.

Physicians' Desk Reference to Pharmaceutical and Specialities and Biologicals, 1949, J. Morgan Jones, Editor and Publisher *(Apply Medical Economics, Inc., Rutherford, New Jersey)* is the third edition to bring our desks up to date with all of the changes in formulae and appearance of new drugs and new speciality products.

In matters of seconds, the physician can find the name and manufacturer of over 5,000 specialities. Elsewhere they are classified as to indications, and 1,250 of the more important ones described in detail.

Perspectives in Medicine. ($2.50. *Columbia University Press, New York City)* is the thirteenth series of the Laity Lectures of the New York Academy of Medicine: The Atom in Civil Life; Food and Civilization; On Being Old Too Young; Perspectives in Cancer Research; Psychiatry for Everyday Needs; and the Interrelation of Pure and Applied Science in the Field of Medicine—Certainly all of these are timely and appealing to the public on the basis of their current reading. These essays are well worth reading and pondering.

Coronary Artery Disease, by Ernst P. Boas and Norman F. Boas, ($6.00. *The Year Book Publishers, Chicago)* presents in a working manual all pertinent information and one of the chief causes of illness and death in America today—one that confronts every physician everyday.

Neurological and Neurosurgical Nursing, by C. G. deGutierrez-Mahoney, M. D., and Esta Carini, R. N., ($6.50. *C. V. Mosby Company, St. Louis)* attempts to give directions for effective nursing care of patients in this field where so much progress has been made in recent years.

British Surgical Practice, Volume Four, ($15.00. *C. V. Mosby Company, St. Louis)* has now appeared. Previous volumes have been reviewed in this column. Volume Four covers from "facial palsy" to "hiccough."

Operating Room Technique, by Edythe Louise Alexander, R. N., ($10.00. Second Edition. 668 Illustrations. *C. V. Mosby Company, St. Louis)* has been brought up to date with description of new methods of preparation, sterilization of supplies, sutures and materials for operative use. Several new operations are also described.

Clinical Orthoptics, Diagnosis and Treatment, by Mary Everist Kramer, edited by Ernest A. W. Sheppard, M. D., ($8.00. *C. V. Mosby Company, St. Louis)* is dedicated to the principle that primary consideration must be given to the physiological principles of the binocular vision act itself and the degree of deviation and the attempts to reduce it are secondary to that. It is the functional rather than the anatomical that must always receive the major emphasis.

Discoverers for Medicine, by W. H. Woglom, M. D., ($3.75. *Yale University Press, New Haven, Connecticut)* gives an accurate description of the discovery of the eustachian tube, phagocytosis, heredity, the itch, cause of milk sickness; measurement of blood pressure, respiration; use of digitalis, vaccination, laryngeal mirror, quinine, X-rays, and spectacles.

Symposium on Medicolegal Problems, Series Two, edited by Samuel A. Levinson, M. D., Ph. D., ($5.00. *J. B. Lippincott Company, Philadelphia)* is presented in the easy format of the first volume of a year ago. It presents the medical and legal side of five major questions followed in each instance by a report on the question-and-answer period which adds greatly to the value of the book. These major questions are: (1) The human skeleton in legal medicine; (2) psychiatry and the civil law; (3) psychiatry and criminal law, (4) Federal control of drugs and cosmetics; (5) radiation hazards and health protection in radioactive research.

Nursing for the Future, by Esther Lucille Brown, Ph. D., ($2.00. *Russell Sage Foundation, New York City)* is a report prepared for the

National Nursing Council. It presents an evaluation of our former apprenticeship system and what the nursing profession has given us in its stead. As they have met the need for qualitative service, they fail more and more to meet the quantitative needs of society. Every physician ought to read this report of what intelligent people think should be done about the problem.

The Hospital in Contemporary Life, edited by Nathaniel W. Faxon, M. D., ($5.00. *Harvard University Press, Cambridge, Mass.)* is an excellent summary of the development of the hospital and its place in contemporary life. One of the most interesting of these seven essays is the one by Joseph C. Aub on "The Unsolved Problems."

Widening Horizons in Medical Education. ($2.75. *The Commonwealth Fund, New York City)* is a report of the joint committee of the Association of American Medical Colleges and the American Association of Medical Social Workers, presenting their study of the teaching of social and environmental factors in medicine. This report emphasizes that the three major aspects of illness—physical, emotional, and social—must be included in future teaching in medical schools.

Allergy: What It Is and What To Do About It, by Harry Swartz, M. D., ($2.75. *Rutgers University Press, New Brunswick, New Jersey)* is the latest and one of the best of the popular manuals. The author has formulated his own concept of allergy in a refreshing dynamic situation involving the use of scientific knowledge of Man—no matter in what special discipline it happens to be found. The book is recommended to physicians for their own reading. The concept is so broad and so useful.

Our Threatened Values, by Victor Gollancz, ($2.50. *Henry Ragnery Company, Chicago)* presents a ringing appeal to the conscience of mankind. It is the respect for personality that is being threatened. There is nothing, as Rufus M. Jones says in his introduction, "More important in this present depression of the value of free personality, than the recovery of the lofty conception of the divine right of man as a free person." The author has shaken political thought in England to its foundations.

1948 Year Book of Dermatology and Syphilology, by Martin B. Sulzberger and Rudolph L. Barr, ($5.00. *Year Book Publishers, Inc., Chicago)* is better than ever this year. It has a summary of Dermatology, Syphilology and Allergy that is unequaled elsewhere. Each year your reviewer looks forward to the helpful introductory essay on these volumes. This year is one of the best. Every general physician, dermatologist and allergist is confronted daily with eczematous eruption of the hands. In recent years we have made great progress in understanding and treating these troublesome lesions. All of our knowledge is summarized here by an experienced and skillful team of physicians. You can hardly afford to miss reading this essay.

Fetal and Neonatal Death, by Edith L. Potter, M. D., and Fred L. Adair, M. D., ($3.75. Revised Edition. *University of Chicago Press, Chicago)* tells how in spite of 600,000 more births in 1945 than in 1937, there were about 1,000 fewer still births and 14,000 fewer deaths under one month of age. It tries to answer from what has been learned, how we can reach the "irreducible minimum" in these figures.

The Problem Drinker, by Joseph Hirsh, ($3.00. *Duell, Sloan and Pearce, New York City)* comes to us with the blessings of that great physiologist and student of alcohol and its effect on Man—Dr. Anton Carlson. This book deals, factually and clearly, with a problem of great and growing importance to the individual and to society—the excessive consumption of alcoholic beverages. Everything that both we and our patients should know.

PAMPHLETS

Marriage: 1949 Model vs. Christian Marriage, "How the Church Helps the Christian Family," "Personal Adjustments in Marriage," "Building a Successful Marriage," "Successful Marriage and the Christian Family," "How To Organize a Lively Meeting," (15 cents with a leader's guide at 25 cents, *The National Council, Protestant Episcopal Church, 281 Fourth Ave., New York City)* represents the efforts of the Episcopal Church to save the American home. They make a good package to give to those who are about to marry.

Our Conservation Job, by Stephen Raushenbush, Report Number 4, The Public Affairs Institute (Fifty Cents. *The Public Affairs Institute, 312 Pennsylvania Ave. S. E., Washington, D. C.),* has been issued preliminarily to the National Emergency Conference on Resources to be held in Washington this spring. The list of original sponsors of the Conference is so loaded with radical labor leaders—members of the palace guard of the late Franklin D. Roosevelt, that one quakes with the fear that government ownership, valley authorities, Federalized medicine, and all of the modern tricks to destroy our Republic will be the answers found. In fact, the solution proposed is for a National Resource Corporation which will finance our conservation job on a self-liquidating basis. Nevertheless, this booklet itself is a competent statement of the problem.



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The Ohio State Medical Journal

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JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Cases Illustrating Some Causes for Failure in the Management of Patients with Allergy

MILTON B. COHEN, M. D., and LEWIS E. ABRAM, M. D.

FAILURE to arrest allergic disease can be due to deficiencies in our understanding of the condition or to sins of omission or commission on the part of the physician who treats the patient.

The following case histories illustrate that the most common causes for failure can be divided into the following categories:

1. Mistaken or Incomplete Diagnosis.
   (a) The symptoms are due to some condition other than allergy.
   (b) The symptoms are initiated by a known allergic mechanism but their continuation is due to complicating organic or emotional factors.
   (c) The symptoms are initiated by an allergic mechanism but the specific cause cannot be found.
2. Inadequate Treatment.
   (a) The specific cause is known, but avoidance is not carried out because of:
      (1) Lack of proper explanation to the patient.
      (2) Lack of patient cooperation in carrying out instructions and in reporting for specific treatment.
   (b) Dependence on skin tests and other immunological procedures alone.
   (c) Failure to appreciate the importance of the patient as an entity and to plan the management accordingly.

Submitted September 14, 1948.

The Authors

● Dr. Cohen, Cleveland, Ohio, is a graduate of University of Louisville School of Medicine, 1915; diplomate of American Board of Internal Medicine; member, American Academy of Allergy; visiting allergist, St. Alexis Hospital; and executive vice-president, American Allergy Foundation.

● Dr. Abram, Cleveland, Ohio, is a graduate of University of Georgia School of Medicine, 1932; member, American Academy of Allergy; member of dispensary staff, Mt. Sinai Hospital.

CASE REPORTS

(I) a. T. R., a 65-year-old female, seen first on August 2, 1946, complained of wheezing and difficulty in breathing which began in April, 1945, and continued until October, 1945, when all symptoms disappeared. Similar symptoms recurred in April, 1946, and had become progressively more marked. These were attacks of acute respiratory distress occurring chiefly at night with dyspnea on exertion during the daylight hours. Wheezing was very marked. The first attack in April, 1945, began when she was notified of the death of two sons within a few days of each other.

The past history was non-contributory.

Examination revealed a short, obese female of 65 years and 227 pounds, with pedal edema, moderate cyanosis and marked dyspnea. The heart was moderately enlarged to the left. There was a grade III systolic murmur at the apex which was not transmitted. No thrill could be elicited. The blood pressure was 140 systolic

and 90 diastolic. There were sibilant and sonorous rales throughout both lung fields with some crepitant rales at both bases. The liver was not palpable. Both legs showed large varicosities of the lesser saphenous system.

DISCUSSION

This patient who presented herself because of a diagnosis of bronchial asthma was obviously not suffering from an allergic reaction, but from advanced cardiac disease with left ventricular failure. She was referred to an internist who controlled the symptoms with mercurial diuretics, digitalis and a low salt diet.

* * *

(I) b. D. G., a 38-year-old female, was seen for the first time in November, 1944, with the complaint of perennial asthma for the past 15 years. During childhood, there were frequent nasal symptoms with occasional asthma attacks in the winter time. For the last 15 years, she had had some wheezing daily, severe attacks at least once a month and several of these had required hospitalization and treatment for "status" before relief was obtained. A competent investigation in 1942 had revealed a sensitivity to house dust and immunization with this substance was carried out. Because she had heard that asthma was connected with nervousness, she had consulted a psychiatrist from whom she had eight months of psychiatric management.

Examination revealed a thin woman whose appearance was consistent with her age. She was wheezing. The vital capacity was 44 per cent of normal. Sibilant and sonorous rales were heard in both lung fields; the heart was normal both to physical and fluoroscopic examination. The diaphragms were low and limited in excursion. The sputum contained numerous eosinophiles. The only significant skin test was a positive reaction to house dust.

Adequate house dust precautions were instituted at home, immunization with house dust was begun, and further historical conferences were arranged. They revealed that the patient had married at 29 years of age and had one child 5 years of age. Before her marriage she was being courted by two suitors. She was deeply in love with one, but feeling that he would not be a financial success, married the other one with whom she made a satisfactory adjustment. During the conversations, she revealed, however, that she felt extremely guilty because of reveries about the first lover and soon developed sufficient insight to cope wtih these fears.

Within four weeks, she was free of all attacks, but still had slight wheezing on exertion. At the end of four months, she had gained 8 pounds; was completely asthma free and was able to hold a full-time job as well as to manage her home. She remained asthma free during a two-year period of observation.

DISCUSSION

This patient had an extrinsic bronchial asthma complicated by emotional factors. Treatment on immunological or psychological lines alone was not sufficient to control the course of the disease. When both types of management were used simultaneously, the treatment was effective.

* * *

(I) c. C. A., a female of 47, was seen in December, 1945, with the complaint of asthma of two years duration. She had never had any significant respiratory symptoms until June, 1945, when sneezing, nasal stuffiness and rhinorrhea began. The nasal symptoms were continuous with varying degrees of severity until November, 1945, when she began to have a dry spasmodic cough. Within a month after the inception of the cough, wheezing and asthma developed. The attacks varied in intensity and several had required hospitalizaton for "status" when the adrenalin, ephedrine and aminophyllin, which had previously given her some relief, were no longer effective. Between the acute attacks, there was some wheezing and spasmodic cough every day. There was no past history of allergy or of other contributory conditions.

Physical examination revealed a dyspneic woman of middle age with moderate cyanosis of the lips and nails with a very anxious facial expression. The thoracic cage was over distended and the lungs showed findings consistent with obstructive emphysema. The heart was of average size, with a regular rate. There was an accentuated second pulmonic sound. The blood pressure was normal and there were no evidences of cardiac failure. Roentgenograms of the chest demonstrated an enlarged pulmonary conus, low diaphragms, widened interspaces and considerable increase in the hilar markings. The only significant laboratory findings were the presence of numerous eosinophiles in the sputum. Intradermal skin tests were entirely negative. The acute symptoms were partially controlled by aminophyllin, ephedrine and epinephrine, but a complete remission was not obtained.

Because of the severity of the attacks and the general down hill course, a bilateral vagus dissection at the root of the lung was performed in two stages. Within a few days after the operative procedure, the corresponding lung lost most of it's emphysematous character and the diaphragms rose to the tenth rib. Only slight wheezing remained. Within 60 days, however, severe attacks returned and the patient died on Feb. 14, 1948, in an acute attack. Permission for a necropsy could not be obtained.

DISCUSSION

In this patient, the history, course and findings are characteristic of intrinsic asthma. In this condition the pathology is that of an antigen antibody allergic reaction similar to, but more severe and constant than that seen in extrinsic asthma. It differs in that the causative antigen cannot be demonstrated and thus, neither treatment by avoidance or specific immunization can be carried out. The prognosis in cases of this type is always bad and, in fact, most autopsied cases of asthma have been from this group.

It is very important to recognize cases of this type so as to avoid too favorable a prognosis.

* * *

(I) d. H. B., a male, 63 years of age, was first seen in October, 1944, while hospitalized because of a severe attack of asthma. The first attack occurred in December, 1913, at 32 years of age. For 15 years previous to the first definite attack, he had had a dry chronic winter cough, worse at night and on arising. The present attacks began in mid-September. There was dyspnea on exertion when he was free from attacks.

Examination revealed a well-developed and nourished man of 60 with moderate cyanosis of

the lips and nail beds. The thoracic cage was voluminous, the lungs hyperresonant and full of wheezing rales. The diaphragms were at the eleventh rib and were limited in their excursion. There was no evident cardiac enlargement or other abnormality. The blood pressure was not elevated. The pulse rate was 80, regular and of good volume. X-ray examination of the chest revealed an adhesion between the vault of the left diaphragm and the lateral pleura, some increased hilar markings. The cardiac shadow was normal in outline in all positions.

Laboratory examinations were non-contributory except for an immunologically positive reaction to house dust on intradermal testing.

House dust precautions were instituted in the bedroom and immunization with house dust was carried out during a period of one year. The acute attacks were controlled, but dyspnea on exertion continued.

DISCUSSION

This patient had an extrinsic respiratory allergy of long standing which was unrecognized and untreated until secondary changes in the lungs lead to distortion of the bronchioles and changes in the lesser circulation leading to pulmonary hypertension. These residual changes make complete relief impossible and indicate gradual development of cor pulmonale with ultimate right heart failure.

* * *

(II) a. 1. J. S., a male of 63 years, a cabinet maker, was seen in August, 1946, with the complaint of wheezing, cough and pain in the chest, which began in January, 1945, and has become progressively worse. A chronic winter cough had been present for many years. An automobile accident in 1944 was followed by dizziness, swelling of the right leg which was injured in the accident and various other complaints, chiefly pain in the sides of the chest, which had no relation to effort and was not transmitted. He stated that "he thought he could work if he could breathe."

Examination revealed a dyspneic white male of 63, who was not appreciably cyanotic. There were evidences of recent weight loss. The middle turbinates were slightly hyperplastic and there was a mucous polyp in the right nostril. The chest was barrel shaped, the lungs were clear except for an area of high pitched breath sounds and an occasional rale in the right supra scapular region. The diaphragms were low and relatively immobile. The heart sounds were distant, but there was no adventitious sounds. The blood pressure was 130 systolic and 90 diastolic. The pulse rate was 60. There was some tenderness over the right upper quadrant of the abdomen, but the liver was not palpable.

Roentgen examinations of the heart and lungs revealed an increase in bronchial marking with some areas of cloudiness in the right upper lobe which were interpreted as fibrosis. The diaphragms were low, the interspaces widened. The heart shadow was within normal limits. The aorta was elongated and slightly increased in density. An electrocardiogram showed a normal mechanism, a rate of 53-P. R. interval 0.18 Q. R. S. interval 0.06, a slight Q 3 and a low voltage T3. The electrocardiographer reported these findings as within normal limits and attached no significance to them.

Intradermal skin tests revealed strongly positive reactions to house dust, feathers, and india gum, with very slight reactions to grass, tree and ragweed pollens. The sputum was loaded with eosinophiles. We considered this man to be an extrinsic asthmatic with a primary house dust sensitivity and reserved our opinions as to the presence of angina. Accordingly, he was given instructions for the preparation of a dust free sleeping room and treatment with house dust extract was begun.

There was no improvement during a period of one month which is unusual in a case of this type if the diagnosis is correct. In checking back, we discovered that the patient's wife had objected to covering the mattress and pillows with the special impervious covers which had been recommended, but had substituted an old quilt for a pillow and had wrapped the mattress with another. Proper precautions were insisted on and obtained. Within two weeks the patient was asthma free and back at work. He has remained asthma free to this time, June, 1948, but does have occasional attacks of anginal pain.

DISCUSSION

Our failure to impress this patient with the necessity of following the rules outlined for him delayed his recovery. The failure to cooperate was due to his lack of knowledge. It was our responsibility to educate him sufficiently to get his cooperation through understanding.

* * *

(II) a. 2. G. B., a 33-year-old man, was seen for the first time on July 29, 1947, with the complaint of asthma which began in May, 1947. Since the onset there had been several severe attacks, with slight tightness in the chest at various times of the day during the relatively free periods. He had had frequent nasal colds since childhood, but no other allergic manifestations were discovered from his history. There were dogs and cats in his environment.

Physical examination showed no significant organic changes. There was moderate acute emphysema with a normal vital capacity after a test dose of epinephrine. Intradermal tests revealed a strongly positive reaction to house dust, but negative reactions to dog and cat dander. Dust precautions were instituted in his home, immunization with house dust extract was begun and he was urged to free his home of pets. He got rid of the cats, but refused to give up the family dog.

During the next four months there was some improvement, but several attacks occurred on the week ends. Two of these required hospitalization. After further insistence, the dog was sent to a boarding kennel and the house thoroughly cleaned. The attacks ceased within a few days and he has remained asthma free for the past eight months.

DISCUSSION

This man's recovery was retarded by his unwillingness to follow our advice to get rid of his dog, which proved to be an important cause of symptoms in spite of the negative skin test.

* * *

(II) b. A 35-year-old female seen first in October, 1943, has complained of attacks of asthma associated with stuffy nose and rhinorrhea since 15 years of age. The attacks of asthma occur periodically throughout the year

with periods of remission during which there is daily nasal stuffiness and morning sneezing and nasal discharge. The nose itches. The attacks are always more frequent and more severe in late August and September.

A complete allergy investigation performed in 1940 revealed positive skin tests to house dust, feathers, horse dander, india gum and ragweed pollen among the inhalants and to wheat, corn, rye, egg, milk, cabbage, potato, orange, pineapple, spinach and chocolate. She was placed on a diet from which all the positive foods were eliminated. Instructions for the avoidance of feathers, horses and india gum were given and she was treated with house dust and ragweed extracts for one year.

Although there was marked lessening of the symptoms during the ragweed season, the winter nasal symptoms persisted and there were occasional attacks of asthma.

Physical examination revealed a thin woman weighing 100 pounds, who looked older than her stated age, who had obviously lost weight. In addition to the presence of wheezing rales in the lungs and an edematous gray nasal mucous membrane, there was anemia evidenced by pallor of the conjunctiva and a hemoglobin of 11 grams. with a red cell count of 3.2 million.

Intradermal tests revealed reactions to house dust, feathers, animal danders, wheat, and egg. There were no other significant findings.

During the period from 1940 until she was studied in 1943, she had rigidly excluded wheat, corn, rye, egg, milk, cabbage, potato, orange, pineapple, spinach and chocolate from her diet. When she was asked what happened if she ate any of these foods, she stated that they gave her asthma. "How do you know," she was asked, "do you ever eat them?" "No," she replied, "the doctor told me I was sensitive to them and that I should avoid them. I never eat any of them, but I know that if I did, I would have asthma."

Adequate house dust precautions were insisted on and obtained; treatment with house dust and ragweed extracts was carried out and she was urged to eat a high protein complete diet. Dietary cooperation was difficult to obtain as she was afraid of the effects of the foods to which she had been told she was sensitive. During periods of freedom from all allergic symptoms each food was eaten in excess and she was able to prove to herself in about six months' time that she could not produce symptoms by eating any of the suspected foods. Within a year, she had lost her nutritional anemia, was free of all symptoms, and weighed 122 pounds which was adequate for her height and build.

DISCUSSION

This case illustrated the damage which can be done by too great a dependence on skin tests in outlining treatment in allergy. A positive skin test gives a clue to a possible cause of symptoms. The importance of the substance as a cause must be determined by clinical investigation. Food sensitivity which is important in infants and young children decreases with age and only a small number of adults can be proved to be sensitive to foods. While food sensitivity is being investigated by avoidance and re-feeding of the suspected foods, one must see that an adequate diet is eaten. Failure to do this will result in the production of more deficiency disease, rather than more relief of allergy.

(II) c. F. U., a male 35 years of age, consulted us on April 10, 1948, because of asthma which began in the summer of 1942. Since the inception of the asthma, wheezing has been present daily. In August, 1941, there was an attack of giant urticaria which lasted one month. There was no seasonal variation in the attacks, although nasal symptoms which were present all year round were more marked in August and September. In 1942, he was studied by an allergist who obtained positive skin tests to house dust, grass pollens, ragweed pollens, orris root, alternaria, hormodendrum, cottonseed, milk, beef, pork, and orange. He was given house dust precautions, was treated with a mixture of ragweed pollen, orris root, mold, cottonseed and a stock respiratory vaccine, and was referred to a rhinologist who gave him six post nasal radium treatments to reduce the hypertrophine turbinates. There was little change in his condition and he soon resorted to privine nose drops and an epinephrine spray for symptomatic relief.

Physical examination on April 10, 1948, revealed a well developed and nourished man of early middle age with slight cyanosis of the nail beds. He was wheezing. The nasal mucosa was boggy and there were small polyps under each middle turbinate. The naso pharynx was edematous. The heart was normal in all respects. The lungs were clear except for wheezing rales. The diaphragrms were slightly limited in motion. The vital capacity was 2600 cc.—58 per cent of normal. The sputum contained eosinophiles. The blood picture was essentially normal. These revealed that the nasal symptoms began within a few days after he learned that his mother was ill.

He went home and took her to an otolaryngologist who attempted to remove a tumor from her nose. The operation was not completed because of hemorrhage. Our patient's nasal symptoms began a few days thereafter. Further study of his mother's case indicated that she had cancer and he took the responsibility for the decision not to have her operated on since the majority of the physicians who saw her advised against it. Within six months his mother was dead and his asthma began. His brothers and their wives intimated that he had not done everything possible for his mother and their attitude intensified his own feelings of guilt.

During the interviews, a strong transference was established and he obtained considerable insight. The treatment with ragweed and house dust extract was continued. Within two months, he was using no more drops and had discontinued the use of the epinephrine spray. The vital capacity rose to 4000 cc.—90 per cent of normal and he was free of wheezing.

This patient has not been followed long enough to be sure of the outcome. However, it is evident that he had not responded to anti-allergic management administered over a period of several years. No one who treated him previously had troubled to understand him as a person. When this was done, improvement began and has continued to date. The case again emphasizes Pare's statement that there are no diseases, but only people sick with diseases, and that no methodology alone, no matter how well it be practiced, can be as successful as management of a patient as an entity and a human being.

The Use of Histamine in Bell's Palsy

D. A. SKINNER, M. D.

IN a recent survey of the literature on Bell's palsy, I have found no mention of the use of histamine in its treatment.

Peripheral paralysis of the facial nerve may be due to constitutional, exanthematous and virus diseases; focal infections, hemorrhage, tumors, surgical procedures in the region of the facial nerve, trauma, and exposure to cold and wet. The onset of paralysis is sudden. The paralysis is characterized by inability to raise the eyebrow; the skin of the forehead, lip, and cheek; and to close the eye completely. Females are affected more frequently than males. No age group is exempted. More left facial nerves are affected than right. The right ear, as a rule, is more protected than the left while sleeping or driving a car. In all of my cases, very large external auditory meati were observed, with little or no cerumen. It is my opinion that, in this refrigerated type of Bell's palsy, the exposure occurs through the external auditory canal. The close proximity of the facial nerve and the stylomastoid artery to the canal wall is why exposure to cold in some individuals has such a sudden paralyzing effect. Vasospasm of this artery and its branches play an important role. Other nerves of the body are not so affected, due to the fact that they have no close proximity to the exterior, and are better protected by soft tissues. Partial or complete recovery occurs in a few weeks or months, even up to fifteen months, or else the paralysis is permanent.

The usual treatment in such cases is the elimination of the focus of infection, vitamin therapy, physio-therapy, electricity, and decompression of the nerve.

Horton has used histamine for the treatment of other nerve conditions such as: multiple sclerosis, retrobulbar neuritis, and nerve deafness.

Hansel has also used histamine in the treatment of various conditions, such as histamine cephalgia, tinnitus, and Ménière's.

The successful results obtained from the use of histamine on various nervous and allied disorders has prompted me to try it in three patients with Bell's palsy. In the first and third patients, treatment was administered early and, in the second, 90 days after the onset.

CASE REPORTS

Case 1. Mrs. O., white, female, aged 48 years, was first observed on June 7, 1948, for paralysis of the left side of her face and left eyelids, which occurred after sleeping in a draft. Tinnitus, diplacusis, and a slight deafness of the left ear were noted. There was some complaint of pain within the ear over the mastoid region and over the angle of the jaw. She gave a history of a slight cold for a week preceding onset. Except for a paralysis of the left facial, orbicularis oculi and frontal muscles, the history and physical examination were essentially negative. Mineral oil eye drops were prescribed and histamine therapy was administered as follows:

Date	Histamine Dilution	Results
6- 7-48	0.10 cc. of 1:10,000,000	Improved.
6- 8-48	0.20 cc. of 1:10,000,000	Much improved.
6- 9-48	0.30 cc. of 1:10,000,000	More improved.
6-10-48	0.40 cc. of 1:10,000,000	Complete restoration of muscles
6-11-48	0.10 cc. of 1:1,000,000	Complete return of paralysis.
6-12-48	0.05 cc. of 1:1,000,000	Slight improvement.
6-14-48	0.20 cc. of 1:10,000,000	Complete restoration.
6-19-48	0.20 cc. of 1:10,000,000	Discharged cured.

On June 11, 1948, soon after the administration of 0.10 cc. of 1:1,000,000 histamine, there was a return of the paralysis.

* * *

Case 2. Mrs. M., white, female, aged 27 years, was first observed on March 13, 1948, for a paralysis of the left side of her face and eyelids, which had developed after sleeping in a draft. Perversion of taste and some impairment of sensation of the tongue were complained of. The history and physical examination were negative for any co-existing infections. At this time she was given the following:

1. Vitamin therapy (B-complex and B1).
2. Physiotherapy with strapping of face.
3. Mineral oil eye drops.

No improvement of her condition resulted,

Submitted March 24, 1949.

The Author

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so on June 12, 1948, histamine therapy was instituted as follows:

Date	Histamine Dilution	Results
6-12-48	0.10 cc. of 1:10,000,000	Improved.
6-16-48	0.20 cc. of 1:10,000,000	Almost complete restoration of muscles.
6-19-48	0.10 cc. of 1:1,000,000	Complete return of paralysis.
6-22-48	0.05 cc. of 1:1,000,000	Worse
6-25-48	0.20 cc. of 1:10,000,000	No change.
7- 2-48	0.10 cc. of 1:10,000,000	Slight improvement.
7- 6-48	0.05 cc. of 1:10,000,000	Improving.
7-16-48	0.05 cc. of 1:10,000,000	Marked improvement.
7-20-48	0.05 cc. of 1:10,000,000	Complete restoration.
7-23-48	0.05 cc. of 1:10,000,000	Complete restoration.
7-27-48	0.05 cc. of 1:10,000,000	Discharged as cured.

Case 3. Miss D., white, female, aged 23 years, was first observed on January 19, 1949, for paralysis of the left side of her face and eyelids, which had developed on January 14, after sleeping by a ventilator. The history and physical examination were otherwise negative. Histamine therapy was instituted as follows:

Date	Histamine Dilution	Results
1-19-49	0.05 cc. of 1:10,000,000	No improvement.
1-20-49	0.10 cc. of 1:10,000,000	No improvement.
1-21-49	0.20 cc. of 1:10,000,000	Slight improvement.
1-22-49	0.30 cc. of 1:10,000,000	Slight improvement.
1-24-49	0.40 cc. of 1:10,000,000	Slight improvement.
1-25-49	0.10 cc. of 1:1,000,000	Slight improvement.
1-26-49	0.20 cc. of 1:1,000,000	More improvement.
1-27-49	0.30 cc. of 1:1,000,000	Marked improvement.
1-28-49	0.40 cc. of 1:1,000,000	Marked improvement.
1-29-49	0.10 cc. of 1:100,000	Complete restoration.
1-31-49	0.10 cc. of 1:100,000	Cured.
2- 3-49	0.05 cc. of 1:10,000	(Paralysis did not reoccur
2- 5-49	0.10 cc. of 1:10,000	when dosage was in-
2- 9-49	0.20 cc. of 1:10,000	creased.)
2-15-49	0.30 cc. of 1:10,000	Discharged cured.

SUMMARY

The rapidity of improvement in the three patients was phenomenal. The patients who received histamine early showed a more prompt and marked response. The paralysis reoccurred in two patients when dosage was increased above the optimum effective amount. Complete restoration reoccurred when the proper effective dosage was repeated. In Case 3, paralysis did not reoccur when dosage was increased above optimum effective amount.

It is interesting to note that Case 1 had ear symptoms and Case 2 had tongue symptoms, while Case 3 had neither.

The results obtained in the treatment of Bell's palsy with histamine have been encouraging. Although these observations have been made in only three patients, the results were so striking that the effect of this type of therapy appears unquestionable.

In view of the fact that Bell's palsy usually shows little improvement in months after the onset, any method or form of treatment which is followed by immediate response appears to be most desirable.

KEEPING UP WITH MEDICINE

• PRIMARY bronchogenic carcinoma is second, and almost equal in its incidence, to carcinoma of the stomach.

* * *

• DISEASE fundamentally represents a failure of the organism in its totality to withstand the combined impacts of annoyances of living, improper food, inadequate shelter, exposure through the lack of protective clothing, weather and climate, poisons and infections. When you will break depends upon the ratio between strength of the impact and your nerves and somatic endowment which in turn is dependent upon a balance between your genetic endowment and the state of your nutrition.

* * *

• DIETARY adjuvants in the management of cirrhosis of the liver are indicated—a multi-vitamin capsule twice daily so as to get 20 mgm. of thiamin and 100 mgm. of Nicotinamide, Methionine 1 gram orally, three times daily, is also recommended although its real value remains to be established.

* * *

• THE most important feature in the successful treatment of obesity consists in enlisting the patient's cooperation.

* * *

• OLDER children with untreated cretinism sometime may not benefit by thyroid medication. It may even make them irritable and unmanageable without corresponding improvement in intelligence and development.

* * *

• IN all cases of physical allergy, epinephrine, ephedrine and allied remedies act just as they do in allergy caused by recognized allergens.

* * *

• FROM one-third to one-half of patients with silicosis who have been treated with aluminum dust are reported to have less dyspnea, fatigue, chest pains and cough.

* * *

• CALCIUM gluconate in 1 gram tablets (two chewed and washed down with water) taken three hours after meals is often effective in the control of a chronic diarrhea. Why is not understood.

* * *

• IN chronic brucellosis, any attempt to use a vaccine must be with dilute or oxidized vaccine with the thought of desensitization rather than the production of an immunity.

* * *

• SOME cases of infectious mononucleosis may be extremely protracted, lasting months.—J. F.

Acute Dermatitis and Pneumonitis in Beryllium Workers: Review of 406 Cases in Eight-Year Period with Follow-up on Recoveries

JOSEPH M. DeNARDI, M. D., H. S. VAN ORDSTRAND, M. D., and MORRIS G. CARMODY, M. D.

HEALTH problems encountered in the manufacture and use of beryllium and its compounds have aroused widespread attention during the last eight years. Owing to its valuable properties, beryllium has gained extensive industrial use. Increased production and utility of the metal and its inorganic compounds have resulted in the occurrence among workers of acute dermatologic and respiratory tract manifestations. This report deals only with the acute manifestations that have been encountered in the three plants of two companies in the Cleveland area. The chronic and delayed types of pneumonitis have been observed mainly in employees engaged in handling phosphor in the manufacture of fluorescent lamps.[1, 2]

Since our publications in 1943[3] and 1945,[4] a series of new cases have been added. From 1940 to July 1, 1948, 372 cases of poisoning have been observed among workers in two plants (A and B of one company) producing beryllium, its compounds and its alloys, and 34 cases in the third plant (plant C, the other company). Dermatologic manifestations occurred in 195 cases, while 211 cases displayed major respiratory tract manifestations. Of the 195 patients with dermatitis, 134 showed definite contact plus host hypersensitivity, 59 cases were due to direct contact and 2 cases were unclassified. Of the 211 patients with major respiratory tract manifestations, 121 had tracheobronchitis and 90 had definite chemical pneumonitis. Chemical nasopharyngitis invariably preceded tracheobronchitis and pneumonitis, but frequently occurred independently. However, because of the non-disabling feature and mildness of the symptoms accurate data on its occurrence were not obtained.

DERMATITIS

The skin manifestations may appear as contact or hypersensitive-like dermatitis, as urticarial or hyperemic lesions, discrete papular lesions, papulovesicular lesions or finally as so-called beryllium ulcers. The lesions usually are confined to the exposed parts of the body, but in many cases of host-hypersensitivity there is widespread distribution with urticarial reaction.

Unquestionably the element of individual hypersensitivity influences the time of appearance and the extent of the dermatitis. Over 25 per cent of new employees in contact with the fumes and dusts of the various beryllium inorganic salts show varying degrees of allergic-like or hypersensitive-contact type of dermatitis on the exposed parts of the body. In almost all cases the dermatologic manifestations appeared in from three to ten days after initial exposure.

Severity and extensiveness of the dermatitis were dependent on relative host hypersensitivity, concentration and duration of contact with the offending fumes and dust, mechanical injury to the derma, excessive environmental humidity, excessive perspiration, failure to observe safety precautions, and poor personal hygiene—all of which are recognized contributing factors. However, it has been observed that a high percentage of patients with severe dermatitis developed an identical skin manifestation upon a second exposure in spite of all protective precautions, and that numerous persons who contracted dermatitis on first exposure developed bronchitis and finally pneumonitis when continuing in the same work. Hence, severe or hypersensitive-like dermatitis occurring in new workers has been

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considered a rough indicator of individual susceptibility to pulmonary or bronchial irritation.

Because of increasing beryllium production, new workers have been employed, with consequent rapid turnover. Loss of manpower has posed an alarming production problem and the incidence of dermatitis has not decreased.

The primary etiologic factors which have been found to produce skin lesions are the salts and solutions of beryllium sulfate tetrahydrate, beryllium sulfate anhydrous, beryllium fluoride, and ammonium beryllium fluoride. It is difficult to evaluate definitely the part played by the element beryllium per se and that played by the acid radical of the inorganic salts. It has been observed that there have been no dermatologic manifestations in persons handling beryllium metal alone. It is probable that the lesions result in most instances from a combination of individual hypersensitivity plus the irritating effects of the acid radical of the inorganic salts.

Symptoms in the majority of cases of dermatitis consist of a burning sensation and pruritus of the affected parts. Treatment includes the use of the usual anti-pruritic lotions and ointments. During the last two years, the anti-histaminic drugs such as benadryl hydrochloride and pyribenzamine hydrochloride have been used extensively both therapeutically and prophylactically with promising results.

BERYLLIUM ULCER

The beryllium ulcer is usually an acute manifestation and if not properly treated may become chronic. The prerequisite for this lesion is a small abrasion of the skin in which minute crystals of beryllium fluoride or beryllium sulfate tetrahydrate become imbedded. Hydrolysis of the crystal in the tissue fluids releases the acid radical, which destroys surrounding tissue and produces an ulcer. The surface layer of the skin tends to heal over the crystal inclusion and ulcer crater and forms a small indurated papule which undergoes necrosis and ultimately forms a small abscess. Microscopic examination reveals increase in surrounding epithelial layers and in the number of fibroblasts around the edge of the ulcer—the usual tissue reaction to a foreign body. Present treatment includes incision of the papule, removal of the crystals in the acute ulcers, and curettage of the fibrous base in both the acute and chronic phases. Healing by second intention is complete within seven to fourteen days.

PNEUMONITIS

Incidence and mortality of pneumonitis, the severest form of this industrial disease, has caused much concern. Three deaths during the year 1943 were reported in plant A alone. Ten deaths have occurred in the 90 cases of pneumonitis diagnosed in the three plants during the eight-year period. Previous to 1939 there were no recorded cases of beryllium poisoning in local plants, although one plant had been in operation since 1935. In late 1942 and early 1943 when knowledge of the disease and its treatment was meager, a relatively large group of cases occurred. Since 1943 relative incidence has subsided considerably, and mortality has been reduced materially.

Despite advanced methods of beryllium determination in the atmosphere of the plant and the plant neighborhood, in tissues of fatal cases, and in urinary excretions in all cases, no experimental method has been devised to determine the part played by the acid radical and that by the beryllium element in the production of the disease. It must be remembered that in the in-plant atmosphere the sulfate and halide radicals and their acids are in relatively greater atmospheric concentration than the beryllium element.

The magnitude of exposure was apparently related in some cases to the occurrence and severity of disease, while in others no such relation could be established. Individual sensitivity, a personal clinical observation, is unquestionably another factor unmeasurable by present methods and undoubtedly has contributed to the occurrence and severity of the disease.

Roentgenographic and clinical findings are the results of irritative phenomena arising from the presence and ensuing reactions of inorganic salts of beryllium in the bronchioles or histamine-like by-products, which cause spasm and partial block of the finer respiratory conduits. Thus exchange of gases in the alveoli is slow, resulting in local anoxia which in turn disturbs the colloidal balance in the tissues and causes fluids to pour out into the alveoli producing edema.[5]

No patient reported in this article nor recovered patients interviewed as late as June 1, 1948, have manifested any other state of ill health nor has there been any chronic or acute disease ascribed to or resulting from the original pneumonitis. The carcinomatosis causing the death in Case 10 and probably originating from the right kidney, is considered coincidental and not related to the pneumonitis.

The present medical program in the industry is one of constant vigilance in the plants and surrounding environment. The engineering problem of decreasing the content of beryllium and its compounds in the working environment and also in the plant neighborhood to the minimum is of paramount importance. Efficient filtration systems for control of the plant exhausts are being installed to make the locality healthful. Rigid pre-employment physical examinations are required of each employee, as are laboratory examinations at frequent intervals with weekly

checks of weights and vital capacity, especially of persons exposed to the offending agents. Adequate instruction in the efficient use of masks and proper clothing, and the cooperation of the worker in maintaining hygienic standards for this industry, will further help to minimize exposure and to decrease the incidence of the disease.

The present program of exchange and correlation of information among the various research and industrial physicians, health engineers, and chemists engaged in the manufacture or in the use of beryllium will aid in the control of industrial hazards. Concentration and centralization of experimental work on this problem will unquestionably promote its early effective control and possibly its solution.

TYPES OF PNEUMONITIS

The two main types of pneumonitis encountered in the two plants were the fulminating type resulting from brief exposures to concentrated fumes or dusts and the insidious type resulting from continual exposure to fumes or dusts over a period of time.

The fulminating type is the least common in occurrence, and usually is associated with exposure to anhydrous beryllium sulfate fumes formed during violent chemothermal reaction in the treatment of finely pulverized beryl ore frit with sulfuric acid. Symptoms may appear within a few hours or as late as 72 hours after exposure, and comprise spasmodic cough, tightness of the chest with substernal pain, severe exertional dyspnea, and in the severe cases varying degrees of cyanosis. Physical examination reveals acrocyanosis, definite and sudden decrease in vital capacity, limited chest expansion, and sibilant rales throughout the chest simulating an asthmatic attack. Recovery in these cases is usually rapid, occurring within seven to sixteen days with adequate medical care.

The insidious type of pneumonitis usually follows prolonged exposure to the fumes or dusts of beryllium sulfate tetrahydrate, beryllium fluoride and beryllium oxide and probably results from cumulative irritation of the bronchioles by small amounts of the compounds. Subjective symptoms in the order of most frequent occurrence are dyspnea on mild physical exertion, spasmodic cough aggravated in the supine position and rarely productive of blood-streaked sputum, substernal burning pressure or pain with tightness of the chest noted especially on the inspiratory effort, general weakness, and anorexia with weight loss commensurate with the duration of the disease before treatment. Dominant objective findings are a pronounced drop in vital capacity, varying degrees of acrocyanosis depending on extent of involvement, fine to coarse inspiratory rales and sibilant rhonchi heard first at the base of each lung and then in the hilar areas, a rapid pulse accompanied by an increased respiratory rate, and a normal temperature except in the presence of secondary infection or infection in the terminal stages of the fatal cases. Laboratory examinations in all cases reveal a normal blood count, sedimentation rate, and urinalysis throughout the course of the disease. Complete recovery may require four to twelve weeks. One patient experienced 166 days of disability.

Roentgenologic changes in the lungs seldom occur in either type of pneumonitis until one to three weeks after onset of symptoms and physical findings. The typical case reveals a particular type of peribronchial haziness and punctate infiltration usually scattered throughout the lower half of each lung field which gives the almost granular appearance seen in pneumoconiosis or one of the mycotic lesions. In severe cases this punctate infiltration progresses to actual consolidation with the "snow flurry" effect resembling at times malignant metastatic lesions.

Treatment for both types consists of hospitalization and the intermittent use of oxygen as indicated. In addition, during the last six months penicillin and the antihistaminic drugs have been used with gratifying results in the relief of respiratory dyspnea and spasmodic cough, and have perhaps shortened the course of the disease. Bronchial and bronchiolar edema with resultant diminished blood supply increase danger of infection by the pathogens of the respiratory tract, and this is probably prevented by the prophylactic administration of penicillin. Antihistaminic drugs relieve the bronchial and bronchiolar spasm by preventing the allergic-like reaction produced either by the primary inorganic irritants or by the histamine-like products resulting from reaction of the inorganic beryllium salts with the body tissues.

Tracheobronchitis, which invariably precedes pneumonitis, may be either rapid in onset or insidious, depending on host hypersensitivity and the type of inorganic irritant. Tracheobronchitis also may exist as an entity. Description and therapy have been given in detail in a previous report.[3] Complete recovery in patients under professional care occurs in seven to twenty-eight days.

The accompanying table shows various types of dermal and respiratory manifestations with the probable causes and the total time of disability in plants A and B.

Twenty cases of recovery from chemical pneumonitis between 1941 and 1948 are reviewed to show complete resolution of the process without evidence of chronicity or recurrence when the patient was removed completely from exposure.

Annual Incidence and Time Lost (in days) Classified According to Probable Causative Agent.
(Plants A and B)

Year	Pneumonitis				Bronchitis				Dermatitis				
	BeF_2	$BeSO_4$	Unclass.	Lost Time Days	BeF_2	$BeSO_4$	Unclass.	Lost Time Days	Contact Hypersensitivity		Contact Only		Lost Time Days
									BeF_2	$BeSO_4$	BeF_2	$BeSO_4$	
1940	—	—	—	———	—	1	—	———	—	—	—	—	———
1941	—	1	1	86	—	1	—	———	—	3	—	—	———
1942	3	3	—	219	3	7	3	81	4	4	1	1	18
1943*	1	—	5	162	5	10	9	397	5	5	—	—	71
1944	—	—	5	477	—	5	2	214	5	5	—	1	92
1945	7	0	—	228	9	6	4	578	12	9	4	—	240
1946	2	—	1	232	9	—	2	208	13	—	5	—	132
1947	14	2	5	644	25	5	7	627	51	9	33	6	740
1948**	6	1	—	261	5	2	1	95	7	2	5		80
Total	33	7	17	2396	56	37	28	2271	97	37	49	8	1418

* 3 deaths
** Complete to June 1, 1948.

One patient in this series died early in 1947 with generalized carcinomatosis.

All beryllium urinary determinations made on patients recovered from acute pneumonitis and not working with the element or its compounds at the present time, reveal the absence of beryllium in the urine.

CASE HISTORIES

Case 1. A 21-year-old man was first employed on January 15, 1941, in the crystallizing process. He was exposed mainly to dust and fumes of beryllium sulfate.

He was admitted to the hospital on March 20, 1941. Four days previously he had been seized with a sudden attack of dyspnea associated with substernal pain and spasmodic cough and had been since confined to bed. He experienced attacks of sweating but no chills. Dyspnea was induced by talking or bending forward. Cough was spasmodic, occurring at irregular intervals, and was productive of a dust-streaked sputum. General malaise and anorexia were concomitant symptoms.

Examination on admission revealed moderate dyspnea and definite acrocyanosis. Bilateral mild palpebral conjunctivitis was noted. Chest expansion was equal, but somewhat diminished. Fine crepitant rales with sibilant rhonchi were heard in the hilar areas and bases. Laboratory findings were normal. Roentgenograms made on April 9 showed diffuse infiltration of both lung fields.

During the hospital say there was slow but definite improvement. Pulse and respiratory rates were elevated, but the temperature remained at a normal level. He was released on April 29 in excellent condition.

Soon after his release the patient joined the armed forces, and at present is on active duty. Roentgenograms made in August, 1947, and again in October, 1948, revealed complete recovery with no evidence of recurrence. Examination on October 13, 1948, revealed the patient to be in excellent physical health.

* * *

Case 2. A 49-year-old man was admitted to the hospital on April 17, 1941. He was first employed on February 26, 1941. About ten days after employment he developed a papular rash of the face and forearms. His face became severely edematous. This condition disappeared in one week without professional care or removal from his working environment. One week after the disappearance of the rash he noticed some exertional dyspnea, exceptional weakness, and spasmodic cough which was aggravated in the supine position. Some blood-streaked sputum was expectorated. Marked hoarseness preceded onset of the cough. Substernal pain on inspiration followed the early symptoms, and the patient experienced anorexia and nausea with a subsequent loss of twelve pounds in weight.

Examination revealed some cyanosis of the lips and fingers. Expansion of the chest was definitely diminished. There were many fine crackling rales audible in both bases and musical rales in the hilar areas. The percussion note was resonant throughout.

The report of roentgenographic examination on April 29, 1941, stated: "There is a generalized mottling of both lung fields, except for the apices and bases, with a soft cloudy infiltration indicating an acute inflammatory condition of indeterminate character."

The patient returned to work in the same plant on June 1, 1941. He was re-examined on August 26, 1947, and June 24, 1948, and found to be in excellent physical condition. Roentgenograms taken at this time were reported as follows: "Examination of the chest shows no residual parenchymal changes in either lung.

The patient has continued to work in the maintenance department since full recovery from the acute chemical pneumonitis in 1941. Employment in the same environment during this long interval has not resulted in recurrence in spite of continuous exposure. Urinary determination made on March 9, 1948, revealed the presence of .8 to 1.2 micrograms of beryllium per liter of urine.*

* * *

Case 3. A 44-year-old white man was first employed in the maintenance department on April 13, 1942. He was admitted to the hospital on May 21, 1942, in a noticeably dyspneic state. Two days previously he was exposed to and inhaled fluoride fumes in concentrated form. A few hours after the exposure he experienced tightness of the chest, spasmodic cough, and appreciable shortness of breath.

Examination on admission revealed the patient to be in respiratory distress; he was severely cyanotic. The temperature was 99.6 F., pulse

* All beryllium determinations by the Kettering Laboratory of Applied Physiology, College of Medicine, Cincinnati, Ohio.

112 beats per minute, and respiratory rate 60 per minute. Chest expansion was greatly diminished with appreciable dullness of the percussion note over the right middle and right lower lobes. There were many moist rales with some tubular breathing over the right middle and right lower lobes. Fine sibilant rhonchi were heard throughout both lung fields.

The diagnosis was acute fulminating pneumonitis with secondary lobar pneumonia on the right.

Oxygen and sulfathiazole were given as indicated. The temperature rose to above 104 F. on two occasions. Respiratory rate ranged between 30 and 60 per minute. A gradual improvement followed and the patient was discharged from the hospital on June 23, 1942, fully recovered.

Interviewed on September 3, 1947, and on May 28, 1948, the patient stated that he was in good health. Report of roentgenographic checkup on May 28, 1948, was as follows: "Examination of the chest shows small pleural adhesions extending from the outer portion of the right dome of the diaphragm and producing some tenting of the diaphragm. The left lung is clear. Impression: Residual fibrosis and pleural adhesion lower right chest. No evidence of any activity at this time."

* * *

Case 4. A 52-year-old man was employed on September 14, 1942, and was assigned to the crystallizing process, where he was exposed to beryllium sulfate solution and fumes.

On October 25, he noticed spasmodic cough and exertional dyspnea. He then developed severe anorexia with concomitant loss of weight. Chest examination revealed limitation of expansion and fine sibilant rales of both hilar areas. The percussion note was unaltered throughout both chests. Roentgenograms confirmed the diagnosis of pneumonitis. Symptomatic treatment was given, and recovery was complete enabling the patient to return to work at the same operation on November 30.

On December 8 the same symptoms recurred. The patient was admitted to the hospital on December 12, 1942. Physical and roentgenographic findings were typically those of chemical pneumonitis.

Improvement was slow, and the patient was sufficiently recovered to be discharged December 31. He returned to work in the maintenance department on January 11, 1943, completely recovered.

The patient was interviewed on September 8, 1947, when he reported that he was doing strenuous work, not in the beryllium industry, and was in excellent health. Report of roentgenographic checkup on September 6, 1947, was as follows: "Examination of the chest shows slight accentuation of the bronchovascular markings. The lung fields are otherwise clear."

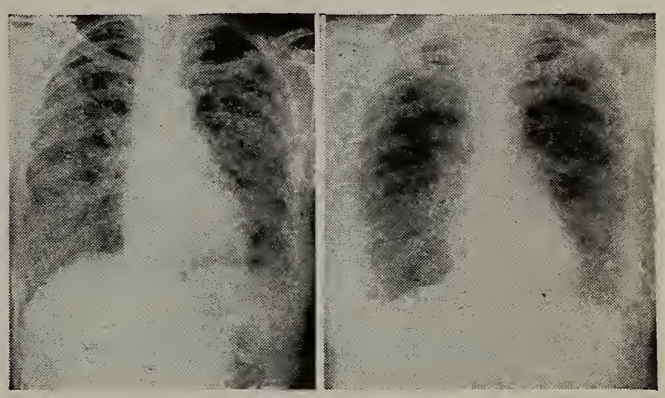
* * *

Case 5. A 39-year-old white woman was first employed as a furnace operator on June 10, 1943. For eight weeks she worked in the department where beryl ore was melted and assisted in the repair of a beryllium fluoride furnace adjacent to her station.

On August 7 she reported for medical examination because of shortness of breath, weakness and spasmodic nonproductive cough with slight streaking of blood in the sputum. These symptoms had been progressive for three weeks, and during this time she had lost fourteen pounds in weight.

The patient was admitted to the hospital on August 18. Examination of the chest revealed limitation of expansion, marked dyspnea, acrocyanosis, and evidence of substernal pain on inspiration. Breath sounds were muffled, and persistent moist squeaky rales were heard over both lung fields.

Roentgenograms demonstrated an atypical nodular infiltration, resembling pneumoconiosis. (Figure 1A.) Laboratory findings were within normal limits.



A B

Figure 1, Case 5. (A) Generalized nodular infiltration of chest thirty-seven days after onset of symptoms. (B) Normal roentgenogram of chest made five years later.

Recovery was slow, and on October 9 the patient was discharged from the hospital in good condition and medically released from the plant.

The patient subsequently had a normal pregnancy and delivery November 8, 1945. On August 16, 1947, and on May 20, 1948, she reported that she was in good health. Roentgenographic reports on these dates stated: "Examination of the chest shows slight accentuation of the bronchovascular markings in both inner lung fields. There is no X-ray evidence of residual fibrosis or other changes from the previous pneumonitis." (Figure 1B.) The beryllium determination in the urine on August 6, 1948, revealed the absence of the element.

* * *

Case 6. A 39-year-old man was employed as a pipe fitter for two weeks before onset of illness. On January 15, 1944, the patient reported for treatment because of exertional dyspnea, nonproductive spasmodic cough, substernal discomfort in the supine position and anorexia with loss of a few pounds in weight. Physical findings and chest roentgenograms were typical of an early pneumonitis.

The patient remained ambulatory and was treated symptomatically. Complete resolution of the pneumonitis was noted about February 11. He was last examined for this illness on March 28, when the chest was found to be normal.

On August 16, 1947, and on June 1, 1948, the patient was re-examined and found to be in excellent physical condition. Roentgenograms made on these dates revealed the following findings: "Examination of the chest shows accentuated bronchovascular markings in the lower right lung region. There is no evidence of any changes as result of previous pneumonitis."

Beryllium determination in the urine, June 10, 1948, revealed the total absence of the element.

* * *

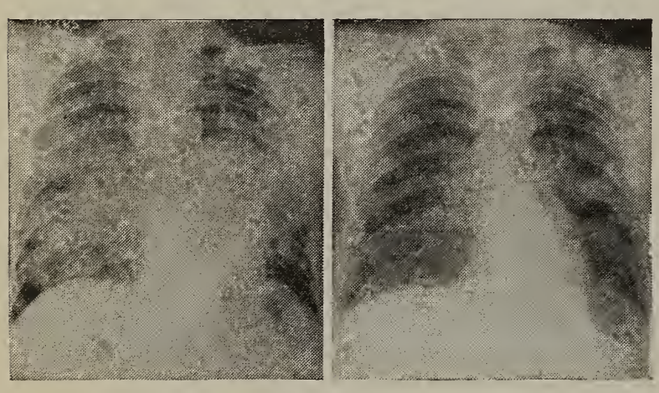
Case 7. A 65-year-old man was first employed as a pipe fitter. He was exposed to considerable dust of beryllium sulfate and beryllium fluoride but to no fumes. On January 18, 1944, he required treatment because of shortness of breath, nonproductive spasmodic cough, severe weakness, substernal pain on inspiration, and anorexia with some loss of weight. These symptoms began about December 25, 1943, and became so pronounced that he quit his work on January 8, 1944.

Physical examination revealed definite acrocyanosis and dyspnea on the slightest exertion. There were many musical rales evident in the hilar and basal areas of the lungs. Chest expansion was limited. The percussion note was unaltered throughout both lung fields. Roentgenograms on January 20 revealed an early perihilar pneumonitis. There was a progression of the process both clinically and roentgenographically to February 25, when resolution was first noted and chest findings indicated improvement. Roentgenograms taken on May 19 revealed complete clearing, except for some residual fibrosis.

The patient was re-examined on August 23, 1947, and on May 24, 1948, and found to be in excellent physical condition. Roentgenograms on these dates were described as follows: "Re-examination of the chest shows linear streaky shadows of density in both lower inner lung fields suggesting fibrosis. No parenchymal infiltration is evident." Urine determination on June 10, 1948, revealed absence of any traces of beryllium.

* * *

Case 8. A 34-year-old man was employed as a pipe fitter on December 16, 1943. He was exposed to dust containing beryllium sulfate and beryllium fluoride. On January 29, 1944, he required treatment because of exertional dyspnea, spasmodic cough with some blood-streaked sputum, substernal discomfort aggravated by coughing or when in the supine position, and anorexia with weight loss of five pounds. Physical examination revealed course, musical rales of the hilar and basal areas of the lungs. Expansion of the chest was below normal and produced pain in the substernal area. The percussion note was resonant throughout.



A B

Figure 2, Case 8. (A) Roentgenogram of chest, twenty-five days after onset of symptoms showing bilateral symmetrical infiltration. (B) Recent negative roentgenogram.

The patient was removed from his work and treated symptomatically as an ambulatory patient. Roentgenograms of the chest confirmed the clinical diagnosis of chemical pneumonitis. (Figure 2A.) He improved gradually and was free of any symptoms on March 24. He returned to work April 5, when roentgenograms showed complete clearing of the process.

Checkup roentgenograms on September 6, 1947, and June 1, 1948, were reported as follows: "The chest appears clear at this time. No residual pulmonary fibrosis or other changes." (Figure 2B.) Urinary determination on June 10, 1948, revealed the absence of any traces of beryllium.

* * *

Case 9. A 47-year-old man was first employed in the maintenance department on March 2, 1944, building and rebuilding gas-fired reduction furnaces in all departments, but principally in the beryllium metal department. He was exposed to dusts of copper oxide, beryllium oxide, beryllium fluoride, magnesium fluoride and beryllium sulfate, and carbonaceous cement.

On April 5, the patient requested medical care, stating that since March 29 he had a "bad cold," an intermittent productive cough, and a feeling of general weakness, all becoming progressively worse. No specific history of mass exposure could be elicited. The patient said that the acrid odors given off by the carbonaceous cements used in the rebuilding of furnace linings had annoyed him and caused a rather sudden and severe anorexia. The possibility of a toxic agent in the cement was investigated, but analysis of the material was negative. On April 5, examination of the chest revealed none of the unusual findings associated with the industry.

On April 12 the patient complained of intermittent spasmodic cough, general weakness, substernal pain, and exertional dyspnea of nine days' duration. Ten days prior to onset of these symptoms he had rebuilt the ammonium beryllium fluoride reduction furnace. Examination revealed appreciable dyspnea with some acrocyanosis. Chest expansion was definitely below normal. Coarse moist rales were audible at each lung base posteriorly. Substernal pain was elicited on deep inspiration.

The patient was treated symptomatically, and on May 15 returned to the same type of work in the maintenance department.

The same symptoms and physical findings recurred within ten days after re-exposure. Recurrence of pneumonitis was verified by roentgenograms. The patient was disabled from May 25 to September 21 but experienced complete clinical and roentgenographic recovery by the latter date.

In April, 1947, the patient had lobar pneumonia but has been in reasonably good health since. Report of roentgenograms made on August 26, 1947, and May 20, 1948, were as follows: "Examination of the chest shows accentuated bronchovascular fibrosis throughout both lower lung fields. There is slight questionable parenchymal fibrosis in each lower lung field. There are no active changes at this time."

The roentgenographic diagnosis was residual post-inflammatory fibrosis in both lower lung regions. Beryllium determination on June 24, 1948, revealed the absence of the element in the urine.

* * *

Case 10. A 47-year-old man was first employed on September 22, 1944, as a mixer in the beryllium copper department and a furnace operator's helper in the beryl furnace department. Exposure was insidious and mainly to

the dusts of beryllium oxide, graphite, and the element copper, also to fumes of reduced silicates.

Symptoms beginning about November 14 consisted of a "chest cold" associated with spasmodic cough, exertional dyspnea, and substernal pain when in the supine position. Symptoms became progressively aggravated, and physical findings on November 24 were typical of chemical pneumonitis. Diagnosis was verified by roentgenograms.

The patient not only refused hospitalization but also all medication. Symptoms became progressively worse until December 10, but thereafter there was a slow and gradual improvement. All laboratory tests were normal. In spite of his medical antagonism, he made a satisfactory recovery and was clinically free of symptoms and physical findings by March 26. Roentgenograms on March 17 revealed complete resolution of the pneumonitis.

The patient was again seen in consultation on January 14, 1947, because of abdominal distension and jaundice of several months' duration. Examination revealed a severely jaundiced, poorly nourished person in a state of respiratory distress. Chest examination showed limited expansion with coarse moist rales at the bases. The percussion note was relatively dull throughout. The abdomen was distended, and a fluid level could be elicited. The liver edge was three inches below the costal margin, and there was an irregular nodular and firm mass in the region of the right kidney and the ascending colon. Rectal examination revealed a similar irregular firm nodular mass in the cul-de-sac, which was moderately tender.

Roentgenograms of the lungs on this date manifested the following: "Multiple oval opacities scattered throughout both lung fields are noted. No evidence of surrounding pneumonitis. The shadows bear no resemblance to lobar or lobular distribution and seem to cross the interlobar fissures."

The clinical diagnosis was probable hypernephroma of the right kidney with hepatic and pulmonary metastases.

The patient was sent to a veterans' hospital where he died on February 3, 1947. An autopsy was performed, and the final diagnosis was generalized carcinomatosis with many pulmonary metastases.

* * *

Case 11. A 39-year-old white man was first employed on March 27, 1945, as a furnace tender, where he became exposed to beryllium fluoride. On June 1, he complained of spasmodic cough, exertional dyspnea and substernal pain on inspiration, which was aggravated in the supine position, of ten days' duration. He had lost six pounds in weight during this time.

Because symptoms became more pronounced he was admitted to the hospital on June 4. Examination revealed limited expansion of the chest with many fine sibilant rales in the hilar areas. Vital capacity was 76 per cent of computed normal. Mild acrocyanosis was present. Roentgenographic findings confirmed the diagnosis of pneumonitis. During his hospital stay the patient's temperature remained normal. Laboratory findings were also normal. Recovery was complete without any complication, and the patient was discharged from the hospital on June 18.

Upon re-examination on August 15, 1947, and May 22, 1948, the patient was found to be in excellent condition. Roentgenograms on both occasions were reported as follows: "Examination of the chest shows no residual changes in either lung. There is no evidence of any pneumonitis."

* * *

Case 12. A 21-year-old white man was first employed as a furnace operator on April 16, 1945. From July 5 to 10 he had a special assignment in the beryllium metal department in the process of making aluminum beryllium master alloy. On July 11 he complained of substernal discomfort, spasmodic attacks of nonproductive coughing, shortness of breath, anorexia, and weakness of twenty-four hours duration. Chest examination on July 13 revealed fine, wheezy rales of both lungs, limited expansion, shortness of breath, and spasmodic cough. Some acrocyanosis was present.

The patient was treated symptomatically as an ambulatory patient, since he refused hospitalization. The cough and exertional dyspnea gradually subsided over a period of six weeks.

Roentgenograms of the chest on July 17 revealed typical findings of chemical pneumonitis with partial atelectasis of the left lung. Roentgenograms on August 3 revealed initial clearing of pneumonitis. The patient was medically discharged in excellent physical condition on September 4.

He was re-examined on August 25, 1947, and found to be in the same satisfactory condition. Report of roentgenogram made on that date was as follows: "A healthy appearing chest with no evidence of residual changes as result of previous pneumonitis."

* * *

Case 13. A 21-year-old man was employed on September 22, 1946, in the attrition mill. On November 22 the patient requested examination because of a sense of substernal burning pressure, first observed about three days previously and associated with a spasmodic nonproductive cough, worse in a supine position. He had noticed a tendency to shortness of breath on relatively mild effort for the previous twenty-four hours, and had experienced a sense of lassitude and general malaise with definite anorexia for the previous five days. Vital capacity was 102 per cent of computed normal. There was physical evidence of considerable metal dust on the mucous membranes of the nose and throat. The chest was clear to auscultation.

On November 27 the patient was permitted to return to routine duties. At the next weekly routine check on November 29 the nose, throat, and chest were found to be clear, but the vital capacity had dropped abruptly to 90 per cent of normal. The patient was immediately precluded from further work.

Physical examination on December 7 revealed findings typical of pneumonitis. Roentgenograms of the lungs confirmed the diagnosis. The patient was not hospitalized, but was observed frequently. Treatment was symptomatic. Serial roentgenograms of the chest revealed the pneumonitis as undergoing slow resolution.

On March 24, 1947, the patient was fully recovered clinically, and roentgenograms showed complete resolution of pneumonitis. When inter-

viewed on June 1, 1948, the patient stated that his health was excellent.

* * *

Case 14. A 27-year-old white man was employed on October 18, 1946, in the attrition mill. He went to bed on December 26 feeling well. On the morning of December 27 he was aroused from sleep by an attack of acute dyspnea. The attack lasted approximately thirty minutes and was associated with nausea but no emesis. Acute respiratory symptoms subsided rapidly, but the patient noticed a tendency toward dizziness and great general weakness. The acute symptoms were given temporary medical attention by a neighborhood physician. The patient reported for medical observation and treatment on January 4, 1947. Chest examination on this date failed to reveal any objective evidence of a pulmonary pathologic condition.

On January 11 he was again seen because of shortness of breath, spasmodic nonproductive cough, substernal discomfort on inspiration and in the supine position, and anorexia with an appreciable loss in weight.

Physical examination on this date revealed definite evidence of a pulmonary pathologic condition. Chest expansion was definitely restricted. The percussion note was resonant throughout. Fine, crackling, wheezy rales were heard throughout both bases and hilar areas. The chest findings became progressively worse up to January 31. Two weeks later there was definite subjective and objective improvement. On April 19, 1947, the patient was clinically well, and roentgenograms on May 28, 1947, revealed a healthy appearing chest.

Interviewed in November, 1947, and on May 25, 1948, the patient stated that he was in excellent health and was free of all respiratory symptoms. A roentgenogram of May 25, 1948, revealed a healthy appearing chest.

* * *

Case 15. A 61-year old white man was first employed as a carbon-lathe operator on October 6, 1946. On January 8, 1947, he requested medical examination because of shortness of breath, substernal soreness on inspiration, anorexia and weight loss. Examination revealed rapid shallow breathing, and pronounced acrocyanosis. The percussion note was dull throughout both chests, and there were fine, dry rales throughout both lungs.

He was admitted to the hospital January 13 with the typical roentgenographic and clinical findings of chemical pneumonitis. Oxygen and penicillin were given in adequate amounts, and within twelve hours there was remarkable improvement in his condition. His breathing was deeper and less labored, and the substernal pain had practically subsided; oxygen was used only at intervals.

Results of routine laboratory work were within normal limits. His progress was satisfactory and rather rapid considering the severity of the disease. He was released from the hospital on January 28, and returned to work in the same department on March 17. On March 31 there was a recurrence of the same severe symptoms and same findings, and the patient was again hospitalized on April 1.

He was once more given penicillin and oxygen with the same remarkable clinical improvement evidenced on the first occasion. There was no appreciable temperature rise, but the pulse and respiratory rates were above normal. The laboratory findings were again within normal limits. He was released from the hospital on April 12, and medically discharged from the industry on April 28.

Interviewed on August 16, 1947, and May 22, 1948, he stated that he was in excellent health and working every day. Reports of roentgenograms made on these dates were as follows: "Re-examination of the chest shows no residual of the original pneumonitis." Beryllium determination made on July 7, 1948, revealed absence of all traces of the element in the urine.

* * *

Case 16. A 19-year-old unmarried girl was first employed on March 12, 1947, as operator of a rotary furnace reducing beryllium sulfate to beryllium oxide. On March 27 she was transferred to a vibratory separator.

Her illness began on April 12 with a dermatitis of the eyelids which cleared in two weeks. On April 26 she complained of considerable spasmodic coughing, shortness of breath, weakness and fatigue of one week's duration.

Physical findings on May 27 included definite acrocyanosis, fine musical rales of both lungs, and limitation of expansion of the chest. The percussion note was unaltered. Roentgenographic findings were as follows: "A rather diffuse, nonhomogenous, patchy infiltration throughout both lung fields rather suggestive of chemical pneumonitis."

The patient was admitted to the hospital on May 27. Resolution of the pneumonitis was a rather slow process, and she was discharged on June 18, completely recovered. During her hospital stay her temperature was not elevated. Cardiac and respiratory rates were moderately increased. Results of laboratory work were within normal limits.

Interviewed on August 29, 1947, and May 17, 1948, the patient stated that she was in good health. Roentgenograms made on these dates showed no residual pulmonary densities.

* * *

Case 17. A 33-year-old white woman was first employed as a stenographer on January 20, 1947. On May 14 she requested medical examination because of a spasmodic cough, substernal discomfort, shortness of breath, some loss of weight, continual fatigue, and loss of appetite. There was a slight temperature elevation.

Examination revealed rales at the right lung base and in the right hilar area, sibilant rhonchi in the hilar areas, decreased expansion of the chest, and slight acrocyanosis. During her illness the patient was ambulatory. Progress of the pneumonitis was followed with serial roentgenograms.

On July 19, 1947, the patient was clinically well, and the final roentgenograms revealed the lung fields to be clear.

Roentgenograms of her chest on August 29, 1947, and May 19, 1948, revealed no residual changes as the result of the previous pneumonitis.

* * *

Case 18. A 31-year-old white man was employed as an oiler in the maintenance department on January 9, 1947. On February 22 he required treatment because of shortness of breath, spasmodic nonproductive cough, and substernal pain on inspiration. Examination revealed bilateral decreased expansion and unimpaired percussion tone. Diffuse sibilant rales were heard through-

out the lung fields. The patient also had a slight papular rash of the face.

He was hospitalized on February 24. Examination on admission showed slight temperature elevation and increase in pulse rate. Fine, sibilant, dry rales were audible at both bases and in the hilar areas and most pronounced at the right base. The percussion note was moderately dull over the right lower base. Slight acrocyanosis of the extremities was present. Laboratory findings were negative, except for the Kahn and Kline tests, which were strongly positive. The diagnosis was acute chemical bronchitis and acute chemical pneumonitis.

The patient was treated with penicillin and the intermittent use of oxygen with remarkable clinical improvement in less than twenty-four hours. He was released from the hospital on March 24, and returned to work on April 29.

When seen on October 7, 1947, and again on August 9, 1948, he was in excellent physical condition and roentgenograms made on October 15, 1947, and August 9, 1948, revealed no residual changes as the result of the pneumonitis. Beryllium determination on March 9, 1948, revealed the presence of 2 to 3 micrograms of the element per liter of urine.

* * *

Case 19. A 25-year-old white man was employed on October 21, 1946, as a furnace operator in the beryllium metal department. On October 29, he noticed a papular rash of the face and neck with mild exertional dyspnea, non-productive spasmodic cough and anorexia with some weight loss. All symptoms became progressively aggravated and because of the respiratory distress he was hospitalized on October 31, 1946. On the day of his admission ventillatory studies revealed a vital capacity of 60 per cent of normal with a respiratory rate at 35 per minute. There was an extensive red papulo-erythymatous eruption of the face, neck and forearms, also definite acrocyanosis existed and the naso-pharynx was oedematous and injected. The chest expansion was diminished below normal, the percussion note was resonant and unaltered throughout, and sibilant rhonchi were audible throughout both lungs.

On November 27, 1946, there was clinical and roentgenographic evidence of full recovery from the dermatitis and acute pneumonitis. The patient was permitted to return to another department where the magnitude of exposure to beryllium salts was considered minimal. He has been working up to the present time and in addition to improved physical condition he has had no recurrences of symptomatology.

On June 3, 1948, the patient was examined and found to be in excellent physical condition with a weight of 173 pounds. The vital capacity was 102 per cent of normal and the chest roentgenogram revealed no evidence of disease or residue of pneumonitis. Urinary beryllium determination made on March 9, 1948, revealed the presence of .3 to .4 micrograms of the element per liter.

* * *

Case 20. A 24-year-old white man was employed on September 23, 1947, as an operator of a beryllium fluoride furnace. On October 11, 1947, he developed a facial dermatitis and bilateral conjunctivitis as a result of exposure to fumes and dispersoids of beryllium fluoride. Recovery was complete and the patient returned to work on October 17.

On October 29 he presented himself for medical aid stating that since October 24 he had experienced exertional dyspnea, spasmodic nonproductive cough and a sense of thoracic "constriction." Symptoms were insidious in onset, concomitant and progressive.

The physical examination at this time revealed diminished vital capacity from a normal of 102 per cent to 75 per cent. There was evidence of dyspnea and acrocyanosis. The chest expansion was shallow while the percussion note was unaltered throughout. Breath sounds were impaired bilaterally at bases with fine crepitant rales and evanescent sibilant rhonchi throughout both lung fields.

He was admitted to the hospital on November 4, 1947, with the typical syndrome and roentgenographic evidence of chemical pneumonitis. Oxygen, penicillin and antihistamic medications were prescribed with rapid and gratifying results. The laboratory work while in the hospital revealed normal findings.

He was medically released from the industry on December 9, 1947, completely recovered. Interviewed on May 20, 1948, he stated that he was in excellent condition. The roentgenograms taken on this same day reveal a healthy appearing chest with no residue as result of the acute pneumonitis. Beryllium determination made on August 8, 1948, revealed the absence of the element in the urine.

SUMMARY

The existence of a disease entity with acute dermal and respiratory manifestations occurring among workers in plants producing beryllium and its compounds has been recognized for the past eight years. A definite etiologic factor has not been established. Unquestionably host hypersensitivity plays a part in both manifestations.

From 1940 through July 1, 1948, 406 cases presenting one or more manifestations have been encountered in three plants of two companies extracting beryllium from the ore beryl in the Cleveland area. In 90 instances the manifestation was acute pneumonitis, in which 10 deaths occurred.

Recent re-examination of 20 patients who had the severe type of pneumonitis revealed no recurrent or chronic manifestation of the disease and no resultant disability.

So far as is known none of the workers who had acute pneumonitis from beryllium have developed recurrences on chronic conditions such as chronic pulmonary granulomatosis.

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Trichinosis—a Preventable Disease

DAVID F. LEACH, M. D., and HAROLD B. ASHWORTH, M. D.

PREVENTIVE medicine in modern times has touched nearly every field of medical practice and has practically eliminated many diseases which at one time were horrible scourges. Smallpox, which has killed several million people in America alone,[1] now, due to vaccinations, occurs only sporadically and claims few victims. Typhoid fever, which in 1910 alone claimed the lives of several thousand people in the United States, now, because of protection of water supplies and pasteurization of milk, claims only one eighty-fifth as many victims as it did in 1910.[2] Diphtheria, which in 1923 caused several thousand deaths in our country, at present, due to widespread immunizations, brings death to only one-twelfth the number of children that it killed in 1923.[3] Puerperal sepsis, which has probably brought death to millions of parturient women since the world began, caused the deaths of 10 per cent of these women[4] in the hospital practice of a little over a hundred years ago; but, due to the adoption of aseptic technique in the delivery of women in labor, which Semmelweiss advocated exactly one hundred years ago,[4] deaths from childbed fever are uncommon. The danger of peritonitis made abdominal surgery a hazardous procedure only a few decades ago, but, thanks to the adoption of aseptic techniques in the operating room, peritonitis due to faulty technique is infrequent today. Preventive measures in the control of tuberculosis have done much to decrease the incidence of that disease. Even in the field of parasitology there are two diseases which have decreased in incidence because of preventive measures involving the prevention of contact with certain types of mosquitoes; namely, yellow fever and malaria.

INCIDENCE OF TRICHINOSIS IN THE UNITED STATES AT A STANDSTILL

One disease which has not in the least been affected by preventive measures, however, at least in our own country, is trichinosis. According to Gould,[5] this state of standstill has existed for at least fifty years.

The number of cases of trichinosis reported per year in the United States is approximately 300,[6] although this is only a very small percentage of the actual number of cases since most of the cases are either undiagnosed or clinically unrecognizable. Actually, the number of cases is in the millions, for routine autopsies show an incidence of from 10 to 36 per cent[5, 6, 7] in the general population.

The incidence of trichinosis in man, of course, parallels the incidence of trichinosis in hogs. Gould[5] states that the incidence of trichinosis in hogs in the United States in the past fifty years has remained at 1.5 per cent, and he compares this with the incidence in other countries. For example, in Germany the incidence in hogs is 0.001 per cent; in other words, it is only 1/1500 of that of the United States, and it goes without saying that the incidence in human beings in Germany is correspondingly low. According to Beckman,[8] the incidence used to be very high in some parts of Germany.

We know of four cases of trichinosis that have occurred in Ohio in 1947. One of these, a fatal case, is here reported. The other three cases are in or around Lakewood, Ohio. Hathaway* states that his case exhibits an eosinophilia of 37 per cent. These four cases may possibly be Ohio's entire quota of the approximately 300 cases of clinically recognized trichinosis in the United States for 1947.

REPORT OF CASE

The case history of the only one of these Ohio cases which proved to be fatal is as follows:

Mrs. C. L. L., aged 16, lived on a farm outside Neffs, Ohio, with her husband and his relatives, who kept a small number of farm animals, including two or three hogs and young pigs. On this farm there were numerous rats.

One day in December, 1946, the men on the farm butchered so that the family might have some pork. This pork was on hand until the first week in January, 1947. This meat supply was supplemented by the purchase of store meat.

Now, ordinarily there would be nothing unusual about a home butchering, and certainly there would be nothing unusual about the purchase of meat from a store. Mrs. L., however, liked

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* Hathaway, H. R.: Personal communication to D. F. L.

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nothing better than to take a knife, cut off a slice of raw meat, and eat it; hence she ate raw either some of the home-butchered pork or some pork which had been bought at a local store.

CONDITION CONFUSED WITH INFLUENZA

On January 23 the patient noted malaise, and on the morning of January 25 she vomited. Subsequently she developed pains in the muscles of the legs and the back and "in the left breast," and she was nauseated. Her temperature varied between 102° and 104°. A local physician saw her on February 1 and diagnosed her condition as influenza. She was then moved to her mother's home on Rock Hill, where one of us (D. F. L.) first saw her on February 3. At that time she complained that she ached all over. Physical examination at that time revealed an obese young woman with a temperature of 103.9°, redness and swelling of the upper eyelids, marked tenderness over the ribs below the left breast, tenderness of the back muscles, considerable tenderness in both costovertebral angles, and tenderness of the muscles of the calves of both legs, especially posteriorly. The left border of cardiac dullness was 11 cm. from the midline, though the blood pressure was only 108/70. The lungs were clear at this time. The diagnosis of influenza, therefore, seemed to be corroborated. Sulfadiazine therapy was instituted, although it was not expected that this would do much good since the diagnosis was influenza. The next day the patient was given 300,000 units of penicillin in oil and wax. Two days later the temperature was 104°; the pulse rate, 130. The redness of the upper eyelids had regressed, but there was dullness at both lung bases anteriorly and at the right base posteriorly; hence a diagnosis of influenzal (virus) pneumonia was made. Sulfadiazine therapy, which had been discontinued after the injection of penicillin, was then resumed.

Since there had been no improvement in the patient's condition she was admitted to the Reynolds Memorial Hospital at Glendale, W. Va., on the evening of February 7. The diagnoses on admittance were as follow:

1. Influenza with secondary bronchopneumonia.
2. Chronic sinusitis with the following secondary features:**
   a. Chronic myocarditis.
   b. Hypothyroidism.

The patient was started on 40,000 units of penicillin every four hours and hypodermoclyses of normal saline twice daily. Intravenouses could not be given as the patient screamed with pain if an attempt to straighten one of her arms beyond a 140-degree angle was made.

The next night one of us (D. F. L.) thought the patient looked more "toxic" than she had before, and therefore he called the other of us (H. B. A.) in to see the patient with him. The latter said that the patient did not look like a case of pneumonia to him and said he had ordered a blood culture earlier in the day because he had thought she might have a septicemia. Since postabortal infection was considered a possible cause of the suspected septicemia, a vaginal examination was done, but it revealed no bulging in the cul-de-sac. Then one of us (H. B. A.) agreed that there was dullness over the lungs posteriorly, but he found dullness over the left lung rather than the right one. Streptomycin in a dosage of 250,000 units every three hours was started at this time at his suggestion.

It was later learned that on this particular day the latter of us (H. B. A.) had ordered that blood for agglutination tests be taken and sent to Charleston.

The next day the former of us (D. F. L.) found dullness over the left lung posteriorly rather than over the right one.

On February 10, one of us (H. B. A.) did a lumbar puncture. The pressure of the spinal fluid was 220 mm. of water. Laboratory examination of the spinal fluid revealed that the fluid was normal.

The same day a chest plate was ordered, and it revealed that the lungs were clear. Hence influenzal pneumonia and miliary tuberculosis were ruled out, and it was necessary to refer to the chief illness as "undiagnosed disease."

The blood culture revealed no growth after 48 hours of incubation.

Other laboratory findings were as follows: The red blood count was 3,990,000; the hemoglobin, 75 per cent; the white blood count, 14,700. The differential blood count showed 84 per cent polymorphonuclear leucocytes, 10 per cent lymphocytes, and 6 per cent monocytes. The urine showed a two plus albumin and a few granular casts.

CORRECT DIAGNOSIS

Late in the afternoon of February 10 one of us (D. F. L.) saw the patient's husband on the street in Bellaire. Since undulant fever was being considered, the husband was asked whether his wife had drunk any raw milk. He said she had but then volunteered the information that she liked to eat raw meat. When asked whether she had eaten raw meat during January, he said she had.

On the morning of February 11 it was discovered that the patient's temperature, which had been hectic, had reached a peak of 106° during the night. At this time, of course, trichinosis was being considered as a possible diagnosis. A repeat blood smear revealed no eosinophils. That afternoon a perusal of textbooks revealed that there is not an eosinophilia in the acute stage of trichinosis.[9] Hence that same afternoon one of us (D. F. L.), with the help of the other of us, took a muscle biopsy from the lateral head of the patient's left gastrocnemius muscle. A bit of this muscle teased onto a slide and placed under the microscope revealed Trichinella spiralis. Hence trichinosis was the main diagnosis on this patient.

It may be that the patient's cardiac enlargement resulted from the invasion of the cardiac muscle by trichinae. In other words, there may have been an acute myocarditis due to trichinosis.[8] Hence the diagnosis "chronic mycarditis" was dropped.

The patient died on February 12, 1947, at 6:45 a. m.

Later it was learned that the agglutination tests done at Charleston had revealed titers of 1:40 for both B. typhosus and Brucella abortus. Hence the patient apparently had had subclini-

** One of us (D. F. L.) believes, as do others, that chronic sinusitis is the cause of numerous pathological conditions. For reference see Pern, Sidney: Prevention of Degenerative and Mental Diseases. Med. Rec., 159:739-740, Dec., 1946.

cal infections caused by these organisms at some time during her life.

The final diagnoses on this patient were as follow:

1. Trichinosis.
2. Chronic sinusitis with the following secondary feature:
   a. Hypothyroidism.

Just this week a member of the family informed us that the hogs on the farm had been tested but had shown no trichinosis. Hence it seems that the contaminated meat was secured at a store rather than from the family farm.

CONCLUSION

This death and others like it are unnecessary, for there are several methods by which trichinosis can be prevented. These include (1) microscopic inspection of pork, (2) the feeding of cooked garbage to hogs, and (3) the processing of pork.[5] Unfortunately the inspection of pork products by microscopic methods has been discontinued in the United States since 1907.[10] Gould says that the feeding of cooked garbage to hogs, while an effective method of control, is not too practicable because the law concerning this cannot be effectively enforced. He recommends the processing of pork as the most effective method of control.[5]

There are, of course, different methods of processing pork. One method recently advocated is the dehydration of pork at 120° F.[11] Ordinary "curing" of pork does not kill the trichinae, but heating to 55° C. for fifteen minutes for each pound of meat will kill them.[9] Also, six days' refrigeration at 0° F. is equally effective.[9]

Nevertheless, no matter what the method may be, it behooves the physicians of the United States to bring pressure to bear upon the statesmen of our country in order to get them to pass laws which will make some effective method of preventing trichinosis imperative.

People like Mrs. C. L. L. ought not to have to die if their deaths can be prevented.

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The Story Behind the Word: Some Interesting Origins of Medical Terms

Allergy—This term is derived from the Greek words "allos," meaning other, and "ergon," meaning energy. Von Pirquet in 1906 was the first to employ the term to denote sensitivity in human beings.

Antimony:—The name "antimony" is one of the curiosities of philology. The various statements regarding its origin are unsupported guesses. Some of these are as follows: Basil Valentine, a Benedictine monk, about the Fourteenth Century, is credited with introducing this drug into medical practice. He is said to have administered some to his fellow monks who died as a result of the violence of the remedy and hence the substance was given the name antimonachas or monks bane, literally meaning against monks. Another suggestion is that it was called "anti-monas" for the reason that the sulphide was never found alone.

Anesthetic—Anesthesia:—It was Oliver Wendell Holmes, the famous poet-physician, who suggested the names "anesthesia" for the condition and "anesthetic" for the agent and these names have survived. The term is derived from the Greek "an," without and "aisthetos" sensation.

Atropine:—Derives its name from the Greek and Roman Goddess Atropos who was one of the "Three Fates." It was the duty of the Fates to preside over human destinies and spin the thread of life. Clotho, the spinner, spun the thread of life; Lackesis drew out the thread tracing the fate of man; and Atropos cut the thread of life with the shears of destiny. Atropine because of its extremely poisonous properties was named after Atropos whose duty it was to cut short the thread of life.

Clap:—Larcroix relates that the prostitutes of Paris in the Middle Ages were housed in quarters known as Clapiers, and that from this is derived the commonly used term "clap" which, even today, is the accepted vulgar name for gonorrhea.

Chickenpox:—The name is said to have had its origin in the Latin word "Cicer," meaning a chick-pea. It was so called from the indistinct resemblance of the eruption to chick-peas. Morton was the first to use the term chickenpox in the literature and stated that this was its popular name in England.

Cretin:—A word of Swiss origin and the same as the French word Chretien or Christian. Cretins were so called because, being baptized and idiots they were not only washed from original sin, but could commit no actual sin, similarly we call idiots "innocents" in popular language.

—HARRY WAIN, M. D., Mansfield, Ohio.

Ionizing Radiations

REX H. WILSON, M. D.

SCIENCE is on the march. New discoveries are being announced constantly. As each advance is made it creates another problem in handling for those who make use of it. Man in his progress must master the old science as well as the new. The power and the hazards of new devices must be evaluated.

The impact of the atomic age has made it necessary for all persons interested in industrial health to become cognizant of the problems arising from the use of ionizing radiations. Ionizing radiations is a descriptive term for that type of energy which has, as one of its chief characteristics, the ability to ionize the matter through which it passes. It has been recognized for many years that certain types of this radiation are harmful and precautions must be taken in their uses. The damaged hands, amputations, development of multiple carcinomas, and the painful deaths which have occurred to many who have used X-rays and radium bear mute testimony to this fact. Experience gained during the first World War showed that radioactive compounds if improperly handled can be fatal to personnel. It required, however, the splitting of the atom and the birth of the atomic energy industry to crystalize the fact that additional knowledge must be secured with respect to radiation hazards. The tremendous strides already made by the nuclear physicist and physician are well known. Much has been learned about atomic energy effects on humans both beneficial and detrimental. Much more remains to be learned.

TYPES OF RADIATION

Ionizing radiations may be of the following types: alpha, beta, X-or gamma, and neutron. From the standpoint of industrial use at the present time, the alpha, beta, and X-or gamma radiations are of most importance. As the use of atomic energy increases, neutron radiations will take on increasing importance. The alpha, beta, and gamma radiations all result from nuclear fission. X-radiation is quite similar qualitatively to gamma radiation, excepting that the wave length of X-radiation is considerably greater and it is produced artificially in electronic devices, the most common of which is the X-ray tube.

X-RADIATION IN INDUSTRY

The use of X-rays in industrial applications has been tremendously expanded in the past few years. This increased use has also been accompanied by increased operating voltages. It is well known that the penetrating power of X-rays increases as the operating voltage increases. Operating voltages ranging up to one million are not uncommon. X-rays are being used industrially at the present time for the examination of many different items. These include such things as metals, welds, food packages for the presence of foreign bodies, munitions, tires, rubber belts, etc. The X-ray machine is kept in constant use at many of these operations. Proper protection must be provided to operating personnel from exposure to the direct rays, and to the less penetrating secondary radiations which result from the scattering of the primary rays. The scattering of the primary radiations with the production of secondary radiations is often a source of hazard to the unprotected user. In most industries the X-radiations are created by X-ray tubes. However, industrial radiography in which radium is used as the source of gamma rays is also possible.

ELECTRONIC HEATING UNITS

A possible exposure to X-radiation may also result from the use of electronic heating units. This type of heating is finding increased usage, especially in the rubber industry. Theoretically it is possible to obtain X-radiation from the electronic tubes used in these devices if the operating voltage is ten thousand or greater. The X-rays so produced will possess little penetrating power unless the operating voltages are considerably higher and will probably be stopped by the metallic shielding of the unit itself. The amount of X-radiation produced should be determined when designing any of these units in order that proper protection can be provided. It is also well to check the electronic units during their operation to determine the existence of

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any X-radiation in the workroom area. The amount of such radiation can be readily determined quantitatively by using any of the commercial instruments now available for this. Qualitatively its presence can be detected by locating at strategic points near the units, small dental X-ray films and noting the darkening of such films after 24 to 48 hours of exposure. The health committee of the Rubber Section of the National Safety Council is currently engaged in determining the extent of the X-ray hazard which may exist at these units.

ALPHA AND BETA RADIATIONS IN INDUSTRY

Both alpha and beta radiations result from the normal radio-active decay of certain radio-active materials. One industrial use of these radiations is in the static eliminator bars which have been placed on the market within the last few years. These devices are intended to reduce the possibility of fire or explosion occurring in solvent vapor atmospheres by ionizing the air, and, thus, prevent excessive static charges arising. Two types of static eliminator devices are being manufactured at the present time. One contains radium as the radio-active material; the other, polonium. Radium itself is an alpha emitter, but some of its decay products emit both beta and gamma radiations. Polonium is a pure alpha emitter. From the standpoint of external exposure alpha rays present little or no radiation hazard, provided the source of them is kept more than three inches away from the skin. They are stopped by approximately three inches of air and any thin membrane such as the skin itself. Beta and gamma rays, however, vary widely in intensity, with the beta rays of radium C—one of the decay products of radium—having a maximum penetrating power of about 34 feet of air. The gamma rays resulting from this same radio-active process have even greater penetrating power. It is, therefore, self-evident that proper shielding, to protect against harmful exposure to the beta and gamma radiations resulting from these devices, be used.

RADIO ACTIVE ISOTOPES IN INDUSTRY

The use of radio-active isotopes in industry is still confined largely to the field of research and development. This use, however, is certain to increase and will in all probability be applied to various phases of manufacturing within the next few years. Theoretically it is possible to produce radio-active isotopes of a greater majority of the chemical elements. A limited number of these isotopes are at the present time commercially available. Their production and end use is controlled by the Atomic Energy Commission. Their greatest value in industry appears to be in tracing chemical reactions, industrial processes, etc. The types of radiation resulting from these isotopes vary quite widely both quantitatively and qualitatively. Not only must adequate shielding be used to protect operating personnel from the various types of external radiations resulting from the isotopes, but personal contact must be avoided and proper personal sanitation employed to protect against the accidental ingestion or inhalation of any of these materials. The disposal of the radio-active isotopes is also quite a problem.

The use of radio-active isotopes in medicine has been practiced for several years. This usage has been confined largely to radio-active phosphorous and iodine. More recently radio-active carbon with an atom weight of 14 has become available. This material offers tremendous opportunities for unlocking many of the secrets in the biological and physical sciences. When it is realized that carbon is the common element of all organic matter the scope of this opportunity can be somewhat visualized. The production of radio-active plant species, radio-active animals that may in turn produce radio-active serums, and even radio-active viruses and bacteria would not appear to be an impossibility.

EFFECTS OF IONIZING RADIATIONS ON HUMANS

In the study of the effects of ionizing radiation on human beings, it soon becomes apparent that the different body tissues react in different ways. Just as these radiations ionize gases through which they pass, so do they ultimately ionize human tissues. The demonstrable effects arising from their physiological action on the human organisms vary quite widely. Every kind of ionizing radiation is similar in its clinical action. A slight amount of radiation is sufficient to damage white blood cells, whereas the nervous system seemingly can withstand tremendous amounts of radiation. At the present time the most sensitive indicator of possible injury to personnel coming in contact with ionizing radiations is the white blood cell count. A lowering of this is the usual result of exposure to a pathologically effective dose. The lymphocytic elements of the white blood cell series seem to be the most affected. There is a wide range of other tissues which are affected. These vary a great deal in their response. Epilation may occur with skin exposure. Reddening of the skin, atrophic changes or hypertrophic changes may occur after exposure. The reproductive organs may be affected with changes occurring in the gonads. Sterilization may occur or there is a possibility of causing alterations in the offspring. It is of importance to remember that the person at the time of immediate exposure has no indications that exposure is taking place. There is no pain or alteration of sensation, and there is no way in which a person may

learn by his own sensations that he is in a region of danger. Consequently, adequate safeguards to supply this missing information are of importance.

Personnel who are engaged in operations presenting possible exposure to ionizing radiations should be given medical examinations at regular intervals which should include a complete blood count. Their removal from exposure should be demanded at the first indication of an abnormal low white count. The operations themselves should be routinely evaluated for the quantity of radiation existing. The present thinking is to maintain all radiation levels below a value of 0.1 roentgen per eight-hour day. Various commercial devices are available for evaluating these radiation exposures. It is also well to use a monitoring system for exposed personnel. This can be done by having the personnel wear small pocket ionization chambers in the shape of a fountain pen which discharge at a predetermined level—usually 0.1 roentgen. Film badges can also be worn and developed at the end of each day or week and the amount of radiation received by the individual quantitatively determined. A service of this type is commercially available whereby the badges are supplied, developed, and read for a small service charge.

In conclusion, I should like to emphasize that the use of ionizing radiations is a problem which requires close scrutiny on the part of safety, industrial hygiene, and medical personnel. Its use presents tremendous opportunities to industry and will be expanded constantly. This use is hazardous and must be properly controlled or serious injury and death may result to operating personnel.

Fluorine and Its Effect on Teeth

The duration of the caries-inhibiting effect is not fully known. The results of clinical studies continued for three to five years indicate that there is no appreciable loss in prophylactic value with the passage of time.

In order to provide a practical basis for topical applications of fluoride to the teeth of children, it is suggested that a series of applications be given at the ages of 3, 7, 10 and 13 years. These ages should be varied in accordance with the tooth eruption pattern of the individual child. An application at 3 would provide protection for the deciduous teeth. Subsequent applications would provide protection for the permanent teeth during the period of changing dentition; the incisors and first molars at 7, the bicuspids and cuspids at 10 and the second molars at the age of 13.—H. I. Marcotte, D. M. D., Lewiston, Maine; Jrnl. of Maine Medical Assn., Vol. 40, No. 4, April, 1949.

Acquired Hemolytic Anemia

Acquired hemolytic anemia has been recognized as a separate entity on the basis of clinical observations since the first of the century. It is now possible to use laboratory methods as well as clinical evidence to distinguish between acquired hemolytic anemia and other types of hemolytic disorders, so that the syndrome may now be differentiated by the following characteristics:

1. No familial incidence has been noted in our cases nor in series reported by others.
2. The disease may begin in any period of life, and there is usually nothing in the history suggestive of previous hemolytic episodes.
3. The course is acute or subacute in contrast to the usual mild course of congenital hemolytic jaundice.
4. Spherocytosis and consequent increased osmotic fragility may be present, particularly in the severe cases, but it is not a constant feature of the disease.
5. Transfused normal cells become involved in the hemolytic process and are eliminated from the circulation at an accelerated rate.
6. Erythrocytes from patients with acquired hemolytic anemia consistently show evidence of sensitization by an immmune body hemolysin, by the Coombs technique.
7. The response to splenectomy is so variable as to constitute a feature of the disease.

Twelve patients with acquired hemolytic anemia studied at Stanford University Hospital during the past six years have exhibited great variation in severity of the hemolytic process.

In general the course of the disease is usually progressive and shows a tendency to increase in severity. Spontaneous cure of the hemolytic disease was observed in only one instance in a 16-year-old girl with associated pneumonitis. In her case one transfusion did not affect the course of the disease, and the hemoglobin remained at a level of 30 per cent for several days until the pneumonic process subsided. This was followed by a complete and apparently permanent remission in the hemolytic process. A temporary partial remission was observed in one patient who a few weeks later relapsed and underwent splenectomy without improvement. One patient died without splenectomy because of the extreme severity of the disease, and one patient is now under observation and splenectomy has not been performed because of advanced age and complicating lymphatic leukemia. Our series is small, but there is evidence that in general those patients in whom the disease was mild and who underwent splenectomy promptly after the diagnosis was made, did the best.—R. S. Evans, M. D., and Rose Duane, A. B., San Francisco; California Medicine, Vol. 70, No. 4, April, 1949.

Hypoplastic Anemia in a Patient Treated Unfavorably With Tridione: A Case Report

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DURING the last three years, the drug, Tridione (3,5,5-trimethyloxazolidine-2,4-dione), has become available for the treatment of epilepsy and certain other disorders of the central nervous system. Lennox[3] has recently evaluated the results of treatment with the drug in 218 epileptic patients. While it has little, if any, beneficial effect in patients with grand mal seizures, it has been proved to be very effective in controlling petit mal attacks, often after other methods of treatment have been ineffective. Because of the apparent effectiveness of the drug, it can be expected that its use will increase rapidly.

Various side effects have been described[3] of which photophobia, skin rash and gastric distress or nausea were the most common. Fatal aplastic anemia has been described in two patients.[2, 4]

The clinical and autopsy observations in another patient who died with hypoplastic anemia following Tridione therapy are described in this communication.

CASE REPORT

The patient was an 18-year old white female who had experienced petit mal attacks since the age of 2 years, attacks occurring as frequently as 40 times daily. She first received treatment for this when she was 11 years old at which time Dilantin, phenobarbital and mebaral were administered. Improvement was marked but the seizures persisted in mild form. In April, 1946, at the age of 16 years, Tridione was first administered in a dose of one 5 grain (0.32 gm.) capsule four times daily. The seizures stopped entirely but eighteen days after the first dose a skin rash and fever appeared which were thought to represent scarlet fever and the patient was isolated and observed by her physician. After the symptoms had subsided, Tridione was again administered in the same dosage. In June, the dose was increased to one 5 grain (0.32 gm.) capsule five times daily and the patient was well except for an occasional mild petit mal attack. In July, Tridione was increased to 6 capsules daily and for a short time the attacks were completely controlled, but recurred again the following month. The dose was increased until by November, 1946, the patient was taking 8 capsules daily. Typical petit mal attacks continued to occur three to four times each week. On November 2, 1946, a rash over the skin of the chest, neck and back associated with burning and itching developed. Hematologic examination was made at this time with the following results: Erythrocytes 4,200,000 per cu. mm., hemoglobin 14.0 gm. per 100 cc. (90 per cent), leukocyte count 6,000 per cu. mm. The blood film was reported to have shown normal proportions of white cells with no abnormal forms. Platelets were present but a count was not made. Tridione was discontinued. A diagnosis of pityriasis rosea prompted ultraviolet irradiation treatment following which the patient developed a first degree skin burn, temperature of 104 degrees (F) and a sore throat. She was admitted to a hospital where penicillin and sulfadiazine were administered without clinical improvement. During this hospital admission repeated leukocyte counts ranged between 4,000 and 6,000 per cu. mm., not going higher in spite of high fever and the presence of what was regarded as a "septic sore throat." This is interpreted as leukopenia and is thought to represent the onset of bone marrow depression. She was sent home but was readmitted two weeks later when the "tonsillitis" became worse and temperatures to 103 degrees (F) persisted. Further intensive penicillin therapy was of no benefit.

After withdrawal of the Tridione, the patient was given mesantoin, 1-1/2 grains (0.096 gm.) and phenobarbital 1/2 grain (0.032 gm.) four times a day with successful control of the epileptic attacks. On January 7, 1947, she was admitted to the Lakeside Hospital complaining of sore throat, weakness and with a temperature of 103 degrees (F).

Past history was non-contributory.

Family history revealed that her mother had convulsive seizures from early childhood until the age of 8 years.

Physical examination revealed a well developed, well nourished white female appearing acutely ill. The temperature was 104 degrees (F), pulse 148 per minute, respirations 30 per minute and blood pressure 120/72. Petechiae and small ecchymoses were present over the skin and mucous membranes of the arms, lips, oral cavity and conjunctivae. Funduscopic examination was not remarkable. The tonsils were greatly enlarged and presented necrotic foci covered by a gray exudate. The cervical, axillary and inguinal lymph nodes were moderately enlarged and firm, the largest node in the left axilla measuring about 2 cm. in diameter. The liver and spleen were not palpable. Examination of the lungs revealed no abnormalities. Neurologic examination was within normal limits.

Laboratory examination revealed urinalysis to be normal. Hematologic examination on the first

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Selected by H. T. Karsner, M.D., from the Clinco-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals of Cleveland, as the 41st of a series of cases to be published under the heading of "Case Reports Presenting Clinical Problems."

and second days of hospital treatment revealed the following:

	1st Hospital Day	2nd Hospital Day
Erythrocytes	1,460,000 per cu. mm.	1,770,000 per cu. mm.
Hemoglobin	3.4 gm. per 100 cc.	3.7 gm. per 100 cc.
Leukocytes	5,200 per cu. mm.	3,800 per cu. mm.
segmented neutrophils	31.0%	32.0%
eosinophils	4.0%	1.0%
basophils	0	0
unsegmented neutrophils	14.0%	16.0%
lymphocytes	27.0%	39.0%
monocytes	15.0%	9.0%
abnormal mononuclears[1]	4.0%	
blast cells[2]	4.0%	
Reticulocytes	0.6%	
Platelets	0	

1. Cells similar to those seen in infectious mononucleosis.
2. Unclassified immature forms with nucleoli.

Bone Marrow examination on the first hospital day:

Myeloid-erythroid content	1.0 per cent (normal 4-6)
Fat content	1.5 per cent (normal 1-2)
Erythrocyte content	12.0 per cent
Plasma content	85.5 per cent
Neutrophils	13.0 per cent
eosinophils	4.2 " "
basophils	0
unsegmented neutrophils	10.8 " "
metamyelocytes	10.0 " "
myelocytes	10.0 " "
myeloblasts	0.6 " "
lymphocytes	12.5 " "
monocytes	4.4 " "
normoblasts	14.4 " "
erythroblasts	4.8 " "
megaloblasts	1.6 " "
plasma cells	13.0 " "
No megakaryocytes could be found.	
Granulocyte-nucleated red cell ratio	2.36:1 (normal)
Bleeding time: 2 minutes 20 seconds	
Clotting time: 4 minutes 30 seconds	

Multiple transfusions were administered. The patient vomited 300 cc. of clotted blood on the second hospital day. On the third day 200 cc. of clotted blood were vomited and approximately 250 cc. of bright red blood were passed per rectum. Early on the third hospital day the patient developed rapid, shallow respirations, profuse perspiration, rapid pulse, and died as preparations for administration of more blood were being made.

Autosy (9444): The heart weighed 290 gm. Petechiae were present upon the epicardial and endocardial surfaces. The myocardium contained numerous foci of bright red hemorrhage.

The pleural surfaces were smooth, moist, glistening and translucent.

The right and left lungs weighed 420 and 330 gm. respectively. Both lungs were soft, crepitant and on section revealed a moist, grayish pink surface with moderate hyperemia in the lower lobes. A dark red submucosal ecchymosis was present in the trachea.

The spleen weighed 300 gm. The smooth translucent capsule was reddish gray mottled with purple. Section revealed a soft, slightly bulging reddish purple surface uniformly studded with gray foci measuring less than 1 mm. in diameter.

The stomach contained approximately 300 cc. of dark red fluid. The mucosa of the small intestine was purple, flecked with red, and contained a large amount of dark red fluid, as did the colon.

The lymph nodes throughout the body were moderately enlarged and the axillary and peribronchial lymph nodes measured up to 2 cm. in diameter. The lymph nodes were softer than usual and on section revealed a slightly bulging gray surface, flecked with black.

The bone marrow of the sternum was reddish purple. The marrow of the shaft of the right humerus and right femur was red and semisolid. The marrow of the right tibia was yellow and had the consistency of fat.

MICROSCOPIC EXAMINATION

Microscopic examination of the lungs revealed all lobes to show engorgement of small blood vessels—and many foci of extravasation of erythrocytes into the alveoli and interstitial tissues. This was greatest in the left upper lobe. A moderate number of polymorphonuclear and mononuclear cells were present in the interstitial tissues.

The bone marrow of the sternum was extremely aplastic and only approximately 1 per cent of the microsection showed normal hematopoietic tissue. The sternal marrow elsewhere was composed principally of fat cells. Microsections of the vertebral bone marrow revealed most of this tissue to be aplastic and composed chiefly of reticular fibers and occasional cells with karyorrhexis, pyknosis and vacuolization. The marrow of the shaft of the femur was composed principally of fat but approximately 25 per cent of the tissue contained hematopoietic elements, some of which showed numerous erythroblasts and myeloblasts. Foci of hemorrhage were present. The marrow of the shaft of the humerus revealed all of the normal hematopoietic elements. Myeloid cells, megakaryocytes and blast forms were present. Microsection of the medullary cavity of the tibia revealed active blood-forming elements.

Microscopic examination of the lymph nodes revealed a follicular pattern that tended to be obliterated and a sinusoidal architecture that was preserved. There was hyperplasia of small cells resembling lymphocytes and many nuclei had a loose light staining chromatin pattern. Many cells present were larger than ordinary lymphocytes and basophils. The nuclei of these had a dense chromatin pattern. In addition, there were small cells suggesting normoblasts. There was much reticulum and the associated cells showed enlargement. Many were pink-staining, granular and some were degenerate. Erythrocytes and leukocytes were not not clearly shown and appeared to be phagocytized. Mitoses were present in the moderately large cells and in the endothelial cells. Rare multinucleated cells were seen which resembled megakaryocytes.

Microscopic examination of the spleen revealed the splenic architecture to be loosely constructed. The pulp was characterized by an increase in the number of follicular centers which were large and composed of a great increase of loosely arranged reticulo-endothelial cells surrounded by a cuff of leukocytes. The intervening medullary sinuses contained the usual complement of red blood cells and lymphocytes.

The significant anatomical diagnoses included:

1. Anemia, profound.
2. Hemorrhage into the gastro-intestinal tract, extensive.

DISCUSSION

This patient had an aregenerative anemia which clinically was consistent with the diagnosis of hypoplastic anemia. Hemorrhage, the direct cause of death, undoubtedly contributed to the severe anemia but the absence of reticulocytosis

indicated that the anemia was not the result of hemorrhage alone and demonstrated the inability of the bone marrow to respond to the stimulus of hemorrhage. Practical absence of platelets from the peripheral blood and leukopenia with neutropenia also were findings commonly present in hypoplastic anemia.

The enlarged lymph nodes and presence of a small number of immature cells in the peripheral blood suggested the possibility of leukemia to which the other blood changes might have been secondary. The immature cells, which contained nucleoli, were non-specific in appearance and did not have the characteristic appearance of myeloblasts, lymphoblasts, monoblasts or megaloblasts. It has been the experience of one of us (R. W. H.) that the presence of a small number of such immature cells in the blood of patients with hypoplastic anemia is not unusual.

Quantitative studies of the material obtained by aspiration of sternal marrow after the method of Schleicher and co-workers[6] indicated a marked decrease in cellularity of the marrow while the normal granulocyte: nucleated red cell ratio showed that all myeloid elements were about equally reduced. Megakaryocytes could not be found.

The blood and bone marrow findings supported the diagnosis of hypoplastic anemia and failed to offer any evidence for the presence of leukemia.

Autopsy results supported the observations made during life except that the hypoplasia of the bone marrow was not uniform. While hypoplasia was extreme in the sternal and vertebral marrow, areas in the femoral and humeral marrows did not appear grossly abnormal. Such inconsistency between blood and bone marrow findings is known to occur and has been described by others.[5]

The enlargement of the lymph nodes cannot be explained adequately. Changes observed in sections made from nodes obtained at autopsy were not those typical of leukemia. The hypoplasia of the marrow without infiltration of immature or abnormal cells was also not in keeping with a diagnosis of leukemia.

It seems justifiable, therefore, to offer a pre- and post-mortem diagnosis of hypoplastic anemia in this case indicating thereby that an aregenerative anemia occurred during life and that while the bone marrow was not uniformly hypoplastic when studied at autopsy, large areas of the marrow had undergone extreme hypoplasia.

This patient had been started on therapy with Tridione nine months before death and the therapy had been stopped about two months before death when the first evidence of hematopoietic depression, as evidenced by beginning leukopenia, was present. She had been treated with a variety of drugs before Tridione treatment was instituted, and with mesantoin and phenobarbital afterwards, none of which has been reported[1] to have produced changes in the hematopoietic system similar to those observed in this patient. The other two patients who have been reported[2,4] to have died with hypoplastic anemia following treatment with Tridione were similar to this one in that the anemia developed only after several months of therapy.

Blood studies made in another hospital at the time of withdrawal of this drug because of the skin eruption revealed only slight leukopenia. This suggests that regular examination of the blood and withdrawal of the drug probably would not always be effective in preventing hypoplasia, since there was steady progression of the anemia following the withdrawal of the drug. This indicates that, in this patient at least, the process once started was irreversible, a view which agrees with the other cases thus far reported.[2,4]

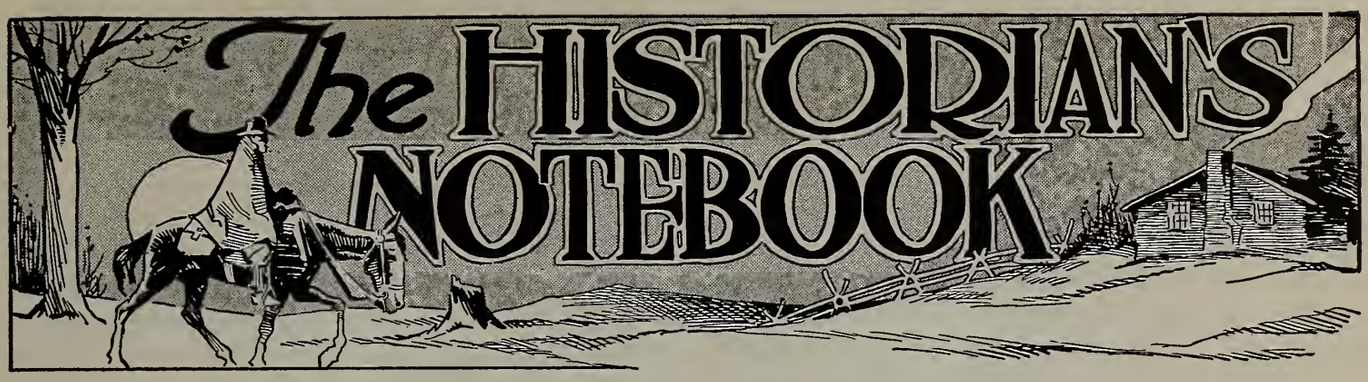
Since this patient was treated with a great many drugs, it cannot be stated categorically that Tridione was the agent responsible for the hypoplastic anemia. It seems reasonably certain that the patient was sensitive to the drug, however, since on two occasions skin rash occurred, once diagnosed as scarlet fever and once as pityriasis rosea, but in retrospect due in all probability to Tridione. Skin rash is not an uncommon finding in patients treated with Tridione and does not necessarily recur on resumption of therapy.[3] In view of this probable sensitivity and since other drugs administered to this patient have not been found to produce a comparable hematopoietic disorder, it seems likely that Tridione was the cause of the hypoplastic anemia in this patient. In any event, since two other patients have died with hypoplastic anemia[2,4] following use of Tridione, we believe that this case should be recorded to emphasize that caution must be observed in the administration of Tridione, the use of which is becoming increasingly popular.

CONCLUSION

The clinical and autopsy observations are reported in a patient who developed hypoplastic anemia after having received therapy with Tridione and a variety of other drugs. It is probable that Tridione was the cause of the hypoplastic anemia.

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The Progress of Anesthesiology in Ohio

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WE do not know definitely who gave the first surgical anesthetic in Ohio, but we do know that Ohio was not backward in applying this great boon to surgical and obstetrical practice. October 16, 1846, was Ether Day, the first public demonstration of ether anesthesia by W. T. G. Morton, at Massachusetts General Hospital. The next year, Sir James Simpson announced the discovery of chloroform anesthesia in Edinborough, Scotland, yet in 1848 we find several articles on anesthesia with reports of cases, published in the *Ohio Journal of Medicine and Surgery.* Dr. R. D. Mussey, the professor of surgery in the Ohio Medical College at Cincinnati, a brilliant surgeon with an international reputation, reported 38 cases done under chloroform anesthesia. He compared it with ether, with which he seemed to have had considerable experience already, and described the advantages and disadvantages of the two drugs. In the same year, Dr. E. C. Bidwell of Keene, Ohio, discussed chloroform in obstetrics, and reported a case of Bandl's contracture that was successfully delivered.

EARLY ANESTHESIA IN OHIO

During the next few years we find much interest in anesthesia and anesthetics in the state. The relationship of certain hysterical and comatose states to anesthesia is considered with speculation as to the underlying cause of these conditions. The anesthetic drugs were used therapeutically in a great variety of conditions, with varying success. Reports of deaths begin to appear, with descriptions of methods of resuscitation, including artificial respiration by mouth-to-mouth insufflation. In 1850, Dr. C. H. F. Routh in blissful ignorance of Lister and Lanstiner, described a method of blood transfusion in which the donor was bled into a basin, from which the blood was injected into the recipient by a syringe and cannula.

In 1851, a number of authors participated in a symposium on anesthesia in the *Ohio Journal of Medicine and Surgery.* There was a full and intelligent discussion that might be read with profit today. Some of the subjects covered were: Does anesthesia increase surgical mortality? The technic of administration, and measures to be used to avoid complications; the relative merits of ether, chloroform, E-C (ether-chloroform) and A-C-E (alcohol-chloroform-ether) Mixtures; the indications for anesthesia, contraindications and choice of agents. While no definite conclusions were reached as to the ideal agent, it was felt that most accidents were the result of technical errors and that anesthesia should be reserved for major procedures. Apparently the high mortality from anesthesia was felt to increase the hazard of surgery, and that it should be avoided whenever possible.

During the last half of the Nineteenth Century there were few advances in anesthesia in Ohio, though it is interesting to note that in 1855, Dr. Horace Green described a tracheal catheter with a curved obturator to be inserted blindly through the mouth for the instillation of drugs into the trachea. This resembled but clearly antedated the familiar laryngeal tube described by O'Dwyer of Cleveland in 1885. The anesthetic was usually given by the practitioner that referred the case to the surgeon; occasionally a surgeon had an assistant or colleague who was accustomed to assist him in this manner. Ether and chloroform were given by the open drop method, and were the only agents commonly used. Nitrous oxide was reserved exclusively for dental extractions; it was given without air or oxygen for short anesthesias only. The administration was often poorly car-

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ried out and complaints were numerous concerning poor operating conditions and high mortality, which was said to be three times that of England.

ENGLISH INFLUENCE ON OHIO

It is true that anesthesia was more advanced in England at this time. John Snow, the first anesthetic specialist, had provided the leadership and stimulus to a more physiological concept of the art. His writings may be studied still with interest and profit. His successor, J. T. Clover, devised apparatus for the administration of ether chloroform and nitrous oxide that was so modern in design that it is still used. Sir Frederick Hewitt elaborated upon the discovery of Andrews of Chicago (1867) that better and safer anesthesia with nitrous oxide resulted when oxygen was mixed with it instead of air. He constructed a machine that for the first time mixed nitrous oxide with definite fractions of oxygen. Nitrous oxide could now be maintained almost indefinitely. This discovery was a milestone in anesthesia, for it opened up the field of gaseous anesthetics, and allowed the anesthetist control of the patient that had been impossible before. Hewitt's "Anesthetics and Their Administration" marks the dawn of modern anesthesia, and his work had important repercussions in Ohio.

About the turn of the century, Charles V. Teter, a dentist of Cleveland, became aware of Hewitt's work, and modified his apparatus for greater convenience and efficiency. He became highly proficient in the administration of nitrous oxide, and soon had accumulated over 100,000 cases for dental surgery. He had a wide reputation which brought him to the attention of a fellow citizen, a surgeon as remarkable for his originality of ideas as manual dexterity, Dr. George W. Crile.

Crile had a new concept of anesthesia and shock. He considered the agents in common use too toxic: "Ether anesthetizes the phagocytes as well as the man, and so places the patient in the position of a citadel, when, at the hour of assault by the enemy, the defenders are asleep in the trenches." He also felt that local anesthesia should be used to block off the impulses from the areas of surgical trauma, while psychic trauma was blocked by general anesthesia. The combination of these agents he called "anoci-association"; we have rediscovered it as "balanced anesthesia." Teter and his nitrous oxide apparatus seemed to solve his problem. In 1910 they reported a reduction in postoperative mortality in 575 cases from 4.4 to 1.9 per cent, and 1915, 15,000 cases had been done under anoci-association without an anesthetic death. Crile was an enthusiast; so much nitrous oxide was used that a plant for its manufacture was set up in the basement of the hospital, whence the gas was piped to the different operating rooms, and his influence was responsible for a great increase in popularity of nitrous oxide, which was now used extensively in major surgery for the first time.

Teter's skill as a technician was rare and irreplaceable. Crile, therefore, decided to teach his own anesthetists, and established, in 1916 at Lakeside Hospital, the first school for anesthetic technicians. That this marked a progressive step in the development of anesthesia is debatable, but surely it must be granted that the anesthetic technician did provide, at that time, an anesthetic service that was much superior to the former practice of employing the ether-dropping general practitioner.

McKESSON AND McMECHAN

A digression is necessary here to introduce upon the scene two men who played a major part in the development of anesthesia in Ohio and the nation. Dr. Elmer I. McKesson of Toledo was the first physician in Ohio to specialize in anesthesia. He was the first to routinely take and record blood pressure during operations, and published many papers discussing the information thus obtained. He was a pioneer in the use of nitrous oxide in intracranial, abdominal, and rhino-laryngeal surgery. These technical advances were possible by his profound physiological knowledge (professor at Toledo Medical College) and mechanical ingenuity, which led to a modification of Teter's apparatus into the McKesson "Nargraf."

Dr. Frank H. McMechan of Cincinnati was an ex-newspaperman turned anesthetist. At one time he served as editor of *The Ohio State Medical Journal.* He saw the need for a publication where the struggling young specialty could express itself, and exchange ideas, and was successful in persuading the editor of the *American Journal of Surgery*, to allow publication of an *"Anesthetic Supplement"* quarterly. McMechan thus edited the world's first journal devoted to anesthesia alone. The outstanding articles were collected annually and published as a "Year Book," for which contributions were also solicited from pharmacologists and others prominent in the basic sciences. From 1912 to 1922 the *Anesthetic Supplement* filled an important role as the only anesthetic journal.

In 1912, the American Association of Anesthetists, the first national anesthetic society, was formed with McKesson and McMechan as charter members. They were active and aggressive in furthering the progress of this society, McKesson serving as president for one term, and McMechan secretary, until the growth of the organization into the Associated Anesthetists of the United States and Canada. Their influence was responsible for the granting of a Session

on Anesthesia at the Annual Meeting of the American Medical Association at Boston in 1921, where McKesson delivered the Vice-Chairman's address: "How Anesthesia May Aid and Protect Surgery."

About this time the young specialty was struck a seemingly knock-out blow. McMechan was completely disabled by a severe hypertropic arthritis; every joint in his body became completely ankylosed, the slightest movement was impossible. But though a helpless cripple there was no arthritis in his active brain, his enthusiasm rose above his handicaps. He immediately accomplished the confederation of a number of regional anesthesia societies with the American Association of Anesthetists as the Associated Anesthetists of the United States and Canada. Their annual meeting was to be clearing house for anesthetic knowledge from all over the world. The first Annual Congress of Anesthetists was held, appropriately enough in Ohio, at the Deshler Hotel in Columbus, October 31 to November 1, 1922.

McMechan would never give another anesthetic, but his abilities were too rare to be wasted. A number of manufacturers of anesthetic supplies and equipment were organized by McKesson to underwrite financially an anesthetic journal of which McMechan was to be the editor. Thus *Current Researches in Anesthesia and Analgesia* was born, published by the National Anesthesia Research Society, of which McKesson was the first president, McMechan full-time editor-secretary.

McMechan was a brilliant writer and speaker, and the success of these projects was assured. It is regrettable that the new generation of anesthetists cannot know this remarkable man. Crippled as he was, he travelled all over the world, strapped to his chair, spreading the gospel of professional anesthesia, an inspiration to everyone he met. His influence on the growth of anesthesia was remarkable. In 1912, the first year that the Directory of the American Medical Association designated specialists, Ohio had three anesthetists, Iva Lickley of Lima, McMechan of Cincinnati, and McKesson of Toledo. By 1918 there were ten, Ray A. Rice of Columbus and A. S. McCormick of Akron having joined McKesson as full-time practitioners. In 1923 there were sixteen, but in two years (1925) the number had increased to fifty-three and in 1929 to ninety. This extraordinary increase could only have been due to McMechan, now devoting his full time to the advance of anesthesia.

In their enthusiasm for professional anesthesia, it is regrettable, though inevitable, that these pioneers should clash with those promoting the training and employment of technicians. In order to legalize the use of technicians, an amendment to the Medical Practice Act of Ohio was proposed. The battle before the State Legislature between McKesson, McMechan and Jones of Columbus representing the anesthetists, and Crile, Follansbee of Cleveland, and Baldwin of Columbus, who favored technicians, was bitter. No quarter was asked or given, and scars still remain. The anesthetists, who perhaps appeared to the legislators to be activated by selfish motives, were defeated, and Ohio became one of the few states where technicians are specifically exempt from the Medical Practice Act. Section 1286-1, "Nothing in this (Chapter of the Act) shall be construed to apply to or prohibit in any way administration of an anesthetic by a registered nurse under the direction of and in the immediate presence of a licensed physician, provided such a nurse has taken a prescribed course in anesthesia at a hospital in good standing."

OHIO NATIONAL'S INFLUENCE

Several other Ohioans played more minor roles in the development of the specialty. Professor Dennis Jackson of the University of Cincinnati was the first one to demonstate that carbon dioxide may be absorbed from anesthetic mixtures. On several occasions he conducted short review courses in fundamental anesthetic pharmacology for clinical anesthetists, and has always been enthusiastically helpful far beyond the call of duty.

Ohio can take some credit for the education of Dr. Ralph Waters, the first full-time professor of anesthesia in the world, whose department at the University of Wisconsin has been the model for similar installation everywhere, and whose influence on anesthetic education cannot be overestimated. Dr. Boyd Stewart, of Tulsa, Oklahoma, the president of the American Society of Anesthesiologists, is a native of Ohio and practiced a number of years in Springfield. In this catalogue of celebrities we must not overlook another pioneer. Anna Hall, of Cincinnati, in 1906, appeared before the Legislature of the State of Ohio, applied for, and received permission to end the suffering of her mother who was afflicted with an incurable disease, by the administration of chloroform.

No specialty can progress without adequate training centers for young practitioners. Though Dr. McKesson had been conducting short, informal postgraduate courses for some years, it was not until 1938 that the first approved anesthetic residency in Ohio was established at Huron Road Hospital, East Cleveland, by Dr. R. J. Whitacre. Dr. J. K. Potter was the first resident. This has grown until at present there are twelve approved hospitals, training nineteen men.

During the 1930's local anesthetic societies had been formed in Cleveland and Toledo, and interest was added to their programs by having a joint

meeting annually, alternating between the two cities. These meetings were so successful that it was thought that a State Anesthetic Society might be feasible, especially as there were now over a hundred anesthetists in the state. The Ohio Society of Anesthetists was organized at Toledo in October 1939 where a constitution was adopted and Dr. Robert Corwin, of Dayton, elected president, Dr. K. C. McCarthy of Toledo, secretary-treasurer. Seventy-five were in attendance from Ohio and neighboring states. Ohio has had, therefore, one of the oldest and most active state anesthetic societies in the nation, and the interest aroused thereby led the Ohio State Medical Association to establish a Section on Anesthesiology, the first session being held at Cleveland in 1947. The scientific presentations at the meetings of these bodies have attracted interest and attendance from all over the country.

GOAL FOR ANESTHESIOLOGY IN OHIO

Anesthesiology has grown in Ohio until at present there are one hundred and seventy-five active practitioners, twenty-five of whom are full-time specialists. If we consider that all these men are well trained, which is certainly not the case, we still have only about one anesthetist for every 125 general hospital beds. This is quite inadequate, for obviously many small hospitals have no medical anesthesia at all. The first goal for anesthesiology in Ohio therefore, should be to have every hospital serviced by a physician with some anesthetic training. The larger institutions should have an anesthetist for every 75 beds. This is minimal coverage, but still will require one hundred more men.

Every major hospital, of 200 beds or over, should have a well-trained man as head of the Department of Anesthesiology. He should hold the Diploma of the American Board of Anesthesiology, or the Fellowship of the American College of Anesthesiologists. To these institutions are referred the problem cases of the community, and first class anesthetic management is essential for modern surgical treatment. In Ohio we have 39 such hospitals, but only 25 fully qualified anesthesiologists.

To supply these needs an extensive educational program is required. Our educational institutions, the medical schools, should provide a leadership that has been sadly lacking. Each school should have a well organized department headed by an outstanding man, capable of directing a modern teaching program for medical students, interns and residents, and postgraduate physicians. Short courses for the general practitioner, who gives the occasional anesthetic in the small hospital, is a pressing need that would raise anesthetic's standards noticeably. This professor should provide such a superior anesthetic service in the University Hospitals that it might be a model for, and inspiration to, the other hospitals of the state.

Furthermore, the university should provide the facilities and personnel so that research in the basic anesthetic sciences might make fundamental and lasting contributions to the progress of our specialty, and thence to medicine as a whole.

History of Medicine

The business of treating sick persons, in the stretch of country now known as Nicollett County, Minnesota, was in the hands of Indian medicine men until 1853, when Fort Ridgeley was established in the western part of the county. Consequently, the first physicians were members of the United States Army. Dr. Alexander B. Hasson, an assistant surgeon, came to the fort in 1853 and was stationed there for a few months. He was succeeded by Dr. Asa W. Daniels, a graduate of the Medical College of Ohio. After a short stay, Dr. Daniels was appointed surgeon to the Lower Sioux Agency, about twelve miles away in Redwood County. It was here, in 1853 or 1854, that an Indian with a bad gunshot wound in his arm was brought to him for treatment. The doctor judged that the arm should be amputated, so he administered chloroform and performed the operation in the presence of the man's friends. This was the first time, so far as anyone knows, that chloroform had been used in the district northwest of the Mississippi. It is said to have made a great impression on the Indians, who spread the news far and wide that there was a white doctor who could make the soul leave the body and then come back again. Months later an Indian medicine man came a distance of "many suns" to get some of this wonderful stuff; but although he offered his pony and all his other possessions, the doctor refused his request, and he returned home a much disappointed man.—Minnesota Medicine, Vol. 32, No. 4, April, 1949.

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The first physician in civil practice to locate in Nicollett County, Minnesota, was Dr. Hiram Wesley Catlin. He came to St. Peter in 1855 and practiced there until 1861, when, as he was about to move to Ohio, he was suddenly taken ill and died. Dr. Catlin was a graduate of the Louisville Medical College and had served in the Mexican war and practiced in Indiana before coming to Minnesota. At the time of his death, his practice in St. Peter was taken over by Dr. Asa Daniels, who returned to Nicollet County to live, and who was to become one of the most prominent physicians in the locality. He served on many local boards and later became one of the first members of the Minnesota State Board of Health. He held membership in various medical fraternities.—Minnesota Medicine, Vol. 32, No. 4, April, 1949.

Study of Child Health Services . . .

Ohio Pediatricians Submit Findings on the Nature of Medical Care Children of State Are Receiving, as Part of Nation-Wide Project

FINAL INSTALLMENT

(Continuation of Chapter IV on "Private Practice")

SUMMARY

1. The amount of physicians' services received by children in Ohio was almost twice that of the lowest state and 69 per cent of the highest.

2. Most of the medical care received by children in Ohio was provided by the general practitioner.

The Percentage of Care by General Practitioners in the County Groups Was as Follows:

Metropolitan	65%
Adjacent	90%
Isolated semi-rural	88%
Isolated rural	97%
Average for State	75%

3. Ohio was the sixteenth ranking state from the standpoint of hospital training in pediatrics for its general practitioners. Only 44 physicians had any postgraduate pediatric training.

4. The average number of patients seen by general practitioners per day was 18. Six per cent reported seeing 50 or more patients per day. No pediatrician saw as many as 50 patients on an average day.

Editor's Note:—On authorization of The Council, The Ohio State Medical Journal has published in installments a report covering a study of child health services and facilities in Ohio, made by Ohio pediatricians who are members of the American Academy of Pediatrics which has sponsored similar studies in many other states. The accompanying article is the third and final installment of the report. The report was compiled by those actively engaged in the study and any conclusions or findings appearing therein are those of the study committee.

INTRASTATE COMPARISONS ON THE AVAILABILITY OF PHYSICIANS

As mentioned previously, Ohio had a ratio of 265 children per physician and the average for the United States was 308 children per physician. As may be noted by comparing the tables below, one may see the variations among the groups of counties.

Availability of Physicians by Geographic Division

Geographic Division	Number of Children Per Physician	Actual Number of Physicians
Group I	210	2163
Group II	312	1055
Group III	335	450
Group IV	268	960
Group V	332	280
Group VI	227	1343
Group VII	482	294

By conventional county grouping, all counties (adjacent, isolated semi-rural, isolated rural) except the metropolitan had a higher ratio of children to physicians than the United States and Ohio averages. In the isolated rural areas, the ratio was two and one-half times as great as the metropolitan areas.

Availability of Physicians by Percentage of Rural Farm Population

Per Cent Rural Farm Population	Number of Children Per Physician	Actual Number of Physicians
50% or more	456	221
40 - 49%	397	248
30 - 39%	375	570
Under 30%	240	5506

By geographic grouping, four divisions (Groups II, III, V, VII) had more children per physician than the United States average, and one additional group (IV) had a slightly higher ratio than the Ohio average.

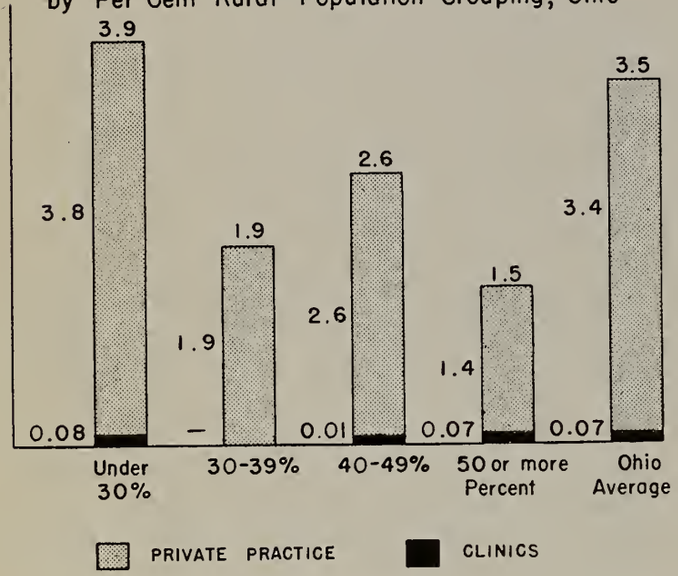
By percentage of rural farm population in Ohio, all divisions having 30 per cent or more rural population had a higher ratio of children to physician than the United States and Ohio

averages. The ratio increased as the per cent of rural population increased.

B. DENTISTS: NUMBER, TYPE, AND TRAINING

In September, 1946, there was a total of 3,677 dentists in private practice in Ohio. Of this number, 2,951 were located in cities of 10,000 or more population. There were 1,073 in the greater metropolitan area, 1,560 in lesser metropolitan, 584 in adjacent counties, 428 in isolated

Fig. 12 Children Under Dental Care on one day per 1000 Children by Per Cent Rural Population Grouping, Ohio



semi-rural, and 32 in the isolated rural. No report can be given as to the number of dentists limiting their practice to one specialty, since 1,123 dentists did not give this information. There was a ratio of 471 children per dentist making Ohio the twelfth ranking state.

Number of Children in Ohio Per Dentist Compared with U. S.

Best Ratio (New York)	273
Ohio Ratio	471
Average Ratio in U. S.[a]	548
Poorest Ratio (South Carolina)	2155

a. Exclusive of New Jersey and Wisconsin.

The number of children per dentist in the various county groups in Ohio was as follows

Number of Children Per Dentist

Greater metropolitan	250
Lesser metropolitan	480
Adjacent	696
Isolated semi-rural	638
Isolated rural	1085

There were no counties in Ohio which were without any dentists in private practice.

Age, Sex, Race, and Training—At the time of the survey, there were 29 female dentists. There were 62 non-white dentists. (Nineteen dentists, for whom race was not reported, were tabulated as white; ten dentists, for whom sex was not reported, were tabulated as male.) About 41 per cent of the dentists were under 45 years of age; 47 per cent were between 45 and 65 years of age, and 12 per cent were 65 or over.

Office Assistants—Of the 1,969 dentists reporting a specified number of total office assistants, 31 per cent had none, 59 per cent had one, and 10 per cent had two or more. Of 1,801 dentists reporting on the number of dental hygienists, 37 reported having one, and one reported having more than one in his office.

DENTAL SERVICES

The number of dental visits per 1,000 children on one day for the whole state was 3.35.

Number Per 1000 Children in Each County Group

Greater metropolitan	6.4
Lesser metropolitan	3.3
Adjacent	2.4
Isolated semi-rural	2.3
Isolated rural	1.2

A total of 2,452 dentists reported seeing an average of 8 patients each day; twenty-four per cent of these were children 15 years or under.

The amount of children's services per day by 1,725 reporting dentists is shown below:

	Children Under 6 Years	Children 6-14 Years
Extractions	275	556
Fillings	529	2011

There were 55 dentists (out of 1,634) reporting a total of 1,832 hours participation in preschool or school dental services covering a period

Fig. 13. Children Receiving Health Supervision on one doy Per 1000 Children in Ohio, Compared with other States

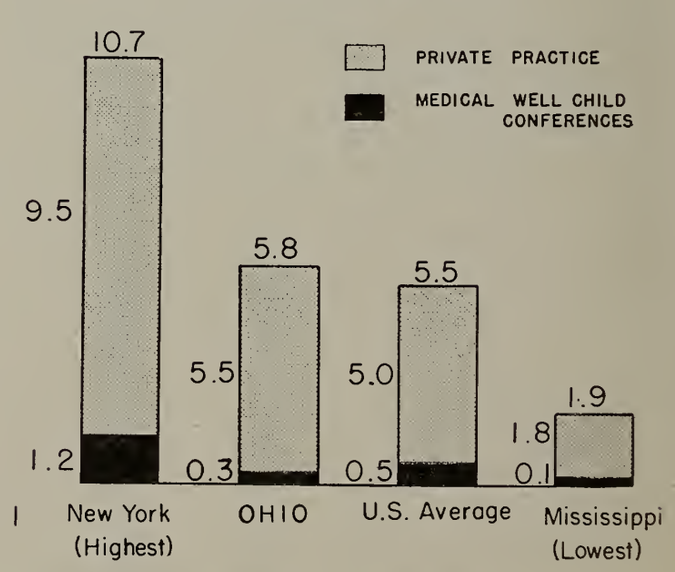
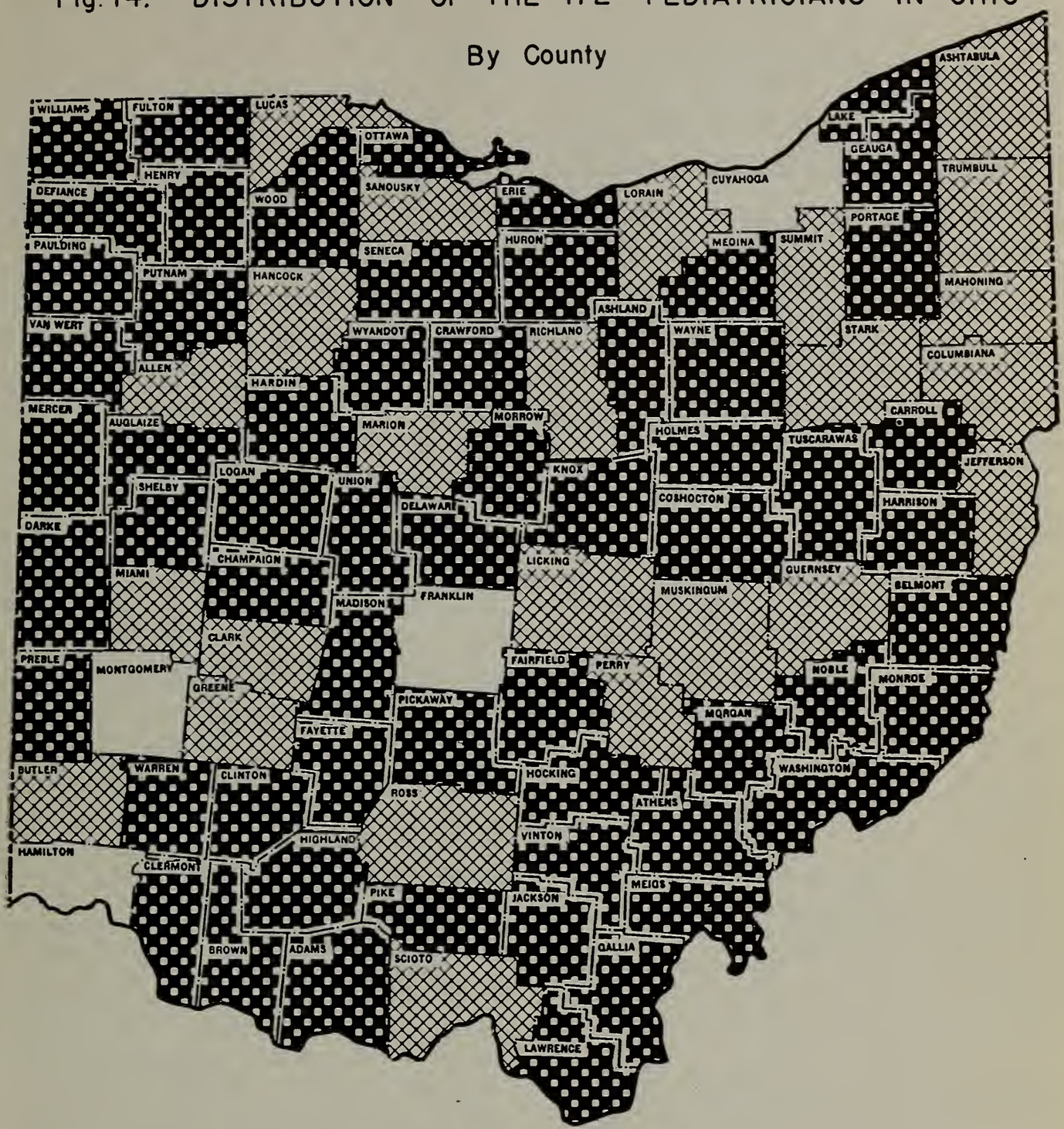


Fig. 14. DISTRIBUTION OF THE 172 PEDIATRICIANS IN OHIO

By County



of four weeks. One hundred and twenty-two dentists reported a total of 1,957 hours participation in other dental activities, such as outpatient clinics and institutional work. The 1,634 dentists reported that during the four study weeks they averaged per dentist per week 41 hours in private practice, 0.3 hours in school dental services, and 0.3 hours in other dental activities.

SUMMARY

1. At the time of the survey, there were 3,677 dentists in private practice in Ohio. Eighty per cent of these were located in cities of 10,000 or more.

2. Comparison by county groups shows the number of children per dentist was greater than the U. S. average in 3 groups (adjacent, isolated semi-rural, and isolated rural) and these, plus the lesser metropolitan areas, were greater than the Ohio average.

3. Fifty-nine per cent of the dentists were 45 years of age or older.

4. Of these reporting, sixty-nine per cent had dental assistants.

5. The average patient load was 8 per day and the child patient load was 2 a day

INTRASTATE COMPARISONS ON THE AVAILABILITY OF DENTISTS

The number of children per dentist by county groups is as follows:

Number of Children Per Dentist by County Group

Greater metropolitan	250	
Lesser metropolitan	480	Poorer than Ohio (471) average
Adjacent	696	
Isolated semi-rural	638	
Isolated rural	1085	

Number of Children Per Dentist by Geographic Division

Group I	310
Group II	562
Group III	644
Group IV	526
Group V	705
Group VI	504
Group VII	864

Below U. S. Average	Below Ohio Average
Group II	Group II
Group III	Group III
Group V	Group IV
Group VII	Group V
	Group VI
	Group VII

Number of Children Per Dentist by Per Cent of Rural Farm Population in Ohio

50% or more	933	Below Ohio (471) and U. S. (548) averages.
40 - 49%	729	
30 - 39%	777	
Under 30%	417	

As may be noted, the number of children per dentist far exceeded the average for Ohio and the United States in the majority of the counties. Obviously there is greater need for more dentists in all but a few areas of Ohio.

CHAPTER V

COMMUNITY HEALTH SERVICES

Community Health Services are those provided for the community by local physicians, local health departments, or by other community agencies These services for children are many and varied although not as numerous nor as well distributed as they might be. Community health services include child health conferences, mental hygiene services, dental clinics, public health nursing, public school services, and services for the physically handicapped.

Below is shown the amount of time spent during one month by the general practitioner and pediatrician in child health conferences, school health services, and other medical activities:

	Hours in Child Health Conferences	Hours in School Health Services	Hours in Other Medical Activities
General Practitioner			
Participating	7.7[a]	10.2	16.1
All Reporting	0.6	1.5	2.5
Pediatrician			
Participating	9.2[a]	24.1	20.6
All Reporting	2.3	2.8	16.5

a. Only 148 (7 per cent) of the 2,010 general practitioners reporting, participated in child health conferences; 31 (25 per cent) of the pediatricians participated in child health services.

A. Child Health Conferences—During the report year, there were 5,407 sessions held in Ohio. Almost three-fourths of the counties (64) had no well-child medical conferences.

The following table shows the number of sessions, patients and visits per 1,000 children under 5 years of age in the county groups:

	Sessions	Patients	Visits
Whole State	8	52	119
Metropolitan	12	78	185
Adjacent	2	10	19
Isolated semi-rural	1	20	21
Isolated rural	0	0	0

The total visits per session averaged 14.9. An average of 2.3 visits was made by each patient.

Of the 5,001 sessions reporting on immunization, 85 per cent reported the practice of routine smallpox and diphtheria immunizations, and 51 per cent reported immunizations for whooping cough. At these sessions 2,145 children were immunized against smallpox, 3,893 against diphtheria, 3,999 against whooping cough, and 282 against tetanus. Ninety-six per cent of the sessions gave advice to mothers on formulae, feeding, care and training. Fifty-one per cent had a consultant service by a nutritionist and 11 per cent had a consulting psychologist or psychiatrist. Considering the fact that 35,177 children attended well-child conferences, the number of immunizations reported is surprisingly low.

B. Mental Hygiene Services—Ohio had 25 agencies conducting mental hygiene clinics for children. There were 14,944 children given care in these clinics, a rate of 8.6 per 1,000 children. Ohio ranked first among the states as to this rate. Twelve states had no service during the year. The United States average was 2.2 patients per 1,000 children and 6.6 visits per 1,000 children. The number of visits per 1,000 children in Ohio

was 17.9. All of the mental hygiene facilities in Ohio were located in 13 counties.[8]

C. Services for the Physically Handicapped—There were 14 centers for the care of children with orthopedic and plastic problems, 1 for rheumatic fever, 3 for speech handicaps, 1 for vision and 1 for hearing handicaps.

Rate of services—The rate of visits per 1,000 children in Ohio was 6.0 for one year. The rates in the various fields of community health are compared in the following table:

Rates for Specified Community Health Services: Visits Per 1000 Children Per Year

	Ohio	Highest	Lowest	U. S. Average
Mental Hygiene	17.9	17.9 (Ohio)	0.1 (Ga.)	6.5
Physically Handicapped	5.9	33.7 (Del.)	1.3 (N. J.)	8.5

D. Public Health Nursing Services—During the report year there were 4 counties[9] with no public health nursing services. The remainder had one or more full-time public health nurses. Public health authorities usually consider, that for a successful and adequate program, there should be one full-time nurse per 2,000 population and about one nurse per 500 children. Ohio was far below this standard with an average of 2,179 children under 15 years of age per full-time public health nurse.

Comparisons With the United States and By County Groupings Are:

Number of Children Per Public Health Nurse

Ohio	2,179
Best (Connecticut)	990
Average in United States	2,475
Poorest (Texas)	9,524

Number of Children Per Public Health Nurse in Ohio County Groupings

Greater metropolitan	1,862
Lesser metropolitan	1,695
Adjacent	3,413
Isolated semi-rural	3,226
Isolated rural	5,780

The total number of home visits per 1,000 children for one year was 225. The United States average was 209.8 visits per 1,000 children. The figures by county groupings were:

Home Visits Per 1000 Children

Greater metropolitan	215
Lesser metropolitan	315
Adjacent	128
Isolated semi-rural	138
Isolated rural	183

Only the metropolitan counties had service as good as the U. S. average amounts of this important service.

E. School Health Services—In Ohio there were nine counties without school medical services,[10] and one without medical or nursing service. In these counties there were 53,563 children or 5.1 per cent of the child population who attended school without benefit of school medical services, and an additional 4,611 who had neither medical nor nursing service at school.

There were 108 health officers and 129 school physicians serving the schools.[11] Of the 129 school physicians, 42 were employed by official health agencies, 64 by official education agencies, 21 by joint official agencies (health and education), and 2 by other agencies. The majority of these physicians were general practitioners (74 per cent). Nineteen per cent were pediatricians, and the remainder other specialists. Of the 570 nurses (unduplicated count), 172 were employed full-time in the schools. More than half of the nurses (333) serving the schools were employed by official health agencies, 147 were employed by official education agencies.

F. Communicable Disease Control—The rate of immunization per 1,000 children given by community health agencies was tabulated for the State and county groupings as follows:

	Smallpox[12]	Diphtheria	Whooping Cough
Whole State[a]	28.5	50.6	7.3
Greater metropolitan	6.6	13.0	6.3
Lesser metropolitan	38.4	60.5	10.4
Adjacent	30.5	54.7	5.8
Isolated semi-rural	21.3	57.3	1.7
Isolated rural	13.8	25.5	12.9

a. Information not obtained from 8 counties.

G. Dental Services—Community dental services include all dental care exclusive of routine mouth inspections. The dentist-hours per 1,000 children in dental clinics in Ohio was 17, making Ohio the fifteenth ranking state.

Dentist-Hours in Clinics Per Year Per 1000 Children

Ohio	17
Highest (Mass.)	121
Average	27
Lowest (Idaho)	0

One characteristic of a good dental service for children is the preponderance of fillings over extractions. Provided both services are freely available, the filling-extraction ratio may be taken as a rough index of the extent to which preventive dentistry is applied. This ratio in Ohio was 2.4 to 1.

SUMMARY

1. Almost three-fourths of the counties had no child health conferences during the report year. There were 8 sessions, 52 patients, and 119 visits per 1,000 children under 5 years of age

in Ohio during the report year. An average of 2.3 visits per patient was made.

2. Of the total child population, 14,944 children received care at mental hygiene clinics during the year.

3. Ohio was far below average in its services to the physically handicapped. The number of visits per 1,000 children per year was only about one-sixth that of the highest ranking state.

4. During the report year there were 4 counties with no public health nursing services. There were 2,170 children per public health nurse as compared to the 500 accepted as the desirable standard.

5. Nine of the counties were without any medical services in public elementary schools.

6. The rates of immunization for the whole state per 1,000 children were: smallpox, 29; diphtheria, 51; whooping cough, 7.3.

7. The rate of visits per 1,000 children made to dental clinics in Ohio was 24.8 which was considerably below U. S. average of 49.4. The highest ranking state was Massachusetts, with 270.6 clinic visits per 1,000 children; the lowest ranking states were Idaho and Louisiana with no dental clinic visits.

CHAPTER VI

HOSPITAL FACILITIES AND SERVICES[13]

A. GENERAL HOSPITALS

Hospitals were included in this study because it is here that children receive inpatient and outpatient care. The following data were gathered from general hospitals of five beds or greater capacity that offered facilities for the care of children.

Facilities and Services for Children (other than newborn)—There are 177 general hospitals[14] in Ohio. One hundred and sixty-two cared for children other than newborn; 72 of these had pediatric units;[15] 60 per cent or almost two-thirds of the hospitals had 100 or less beds.

The general hospitals included in this study had a total of 22,027 beds or 12.7 per 1,000 children. Of these beds 2,196 were set aside for the exclusive use of children. This was 10 per cent of the total hospital beds in the State, whereas, children made up 23 per cent of the total population of Ohio.

Beds (Total) in General Hospitals Per 1000 Children

Highest in U. S. (Nevada)	28.5
Average for U. S.	12.8
Ohio	12.7
Lowest in U. S. (Mississippi)	5.5

The number of beds per 1,000 children was 13.8 in the metropolitan-adjacent counties and 7.8 in isolated counties.

In the following table, pediatric beds in Ohio are compared with other states:

	Pediatric Beds Per 1000 Children	Percentage of Beds Permanently Set Aside Per 1000 Children
Ohio[a]	1.3	10.0%
Highest State (Delaware)	2.4	15.8%
Average in United States	1.2	9.3%
Lowest State (Mississippi)	0.2	3.8%

a. Ohio is 21st ranking state.

Pediatric admissions to general hospitals in Ohio during the report year totaled 96,068 at an annual rate of 55.5 per 1,000 children. Comparison with other states shows that there were 23 states with a higher annual rate of admissions than Ohio. The highest annual rate of admissions in the United States was 97.3 (Nevada), the lowest 25.6 (Tennessee), and the average annual rate was 51.4. The rates by county grouping in Ohio were 61.0 per 1,000 children in the metropolitan-adjacent, and 30.0 in isolated counties. The majority of admissions was to hospitals having 100 or more beds (83 per cent), and only 2 per cent to hospitals having less than 25 beds.

Child Admissions to Larger General Hospitals (25 or More Beds) With Specified Characteristics, by County Grouping in Ohio.

Characteristic	Admissions of Children During One Year			Per Cent of Admissions Occurring in Hospitals With Specified Characteristic		
	With Specified Characteristic	Without or Not Applicable	Not Reported	Whole State	Metropolitan and Adjacent Counties	Isolated Counties
1. Registered by American Medical Assn.	92,025	2,230	0	97.6%	98.6%	88.2%
2. Separate Pediatric Unit.	78,525	15,730	0	83.3	86.4	53.1
3. Separate ward for infants other than newborn	67,558	25,158	1,539	72.9	76.0	42.3
4. Any house staff.	63,807	24,393	6,055	72.3	76.5	28.0
5. Graduate nurse on duty at all times in pediatric unit.	64,924	28,639	692	69.4	72.5	39.3
6. Clinical laboratory in hospital.	86,131	4,237	3,887	95.3	96.5	84.3
7. Qualified dietitian on staff.	79,829	10,865	3,561	88.0	91.7	54.2
8. All milk pasteurized for infants and older children.	88,041	2,996	3,218	96.7	96.4	100.0
9. Selected clinical laboratory services available.	81,518	8,442	4,295	90.6	92.3	75.2

Of the 177 general hospitals, 10 restricted their admissions to white patients, and 2 to non-white patients; 162 admitted both white and non-white. Three hospitals did not report on this item.

Newborn Care—Of the total amount of care for children in general hospitals in Ohio, 57 per cent was for newborn. There were 127,555 births in hospitals during the report year, with an average of 8 days of newborn care. About 4 per cent of these births occurred in hospitals of fewer than 25 beds.

At the time of the study there were 4,213 bassinets and 431 incubators. It is interesting to note that the metropolitan-adjacent areas had 85 per cent of the bassinets and 85 per cent of the births.

Characteristics of Hospitals Caring for Children—The percentage of children admitted to hospitals with specified characteristics is shown in the table on the preceding page.

In comparison with the other states, it was found that seven states had a higher average of child admissions to hospitals with the characteristics specified in the table (with exception of characteristics 1 and 8). The highest averaging state was Delaware with 94 per cent and the lowest Mississippi with 28 per cent; the Ohio average was 81.7 per cent, and the United States average was 72 per cent. This table showing child admissions to larger general hospitals (25 or more beds) with specified characteristics, by county group in Ohio, points out the lack of adequate facilities in the isolated counties. The most evident deficiencies were: separate pediatric units; house staff; graduate nurse supervision.

The following table relates to births in hospitals with specified characteristics:

Characteristic	Per Cent Hospital Births in Hospitals[a] With Specified Characteristics
Any house staff	68.5
Graduate nurse on duty at all times in newborn nursery	94.7
Room used exclusively for preparation of formulae	80.8
Nursery for full-term sick or suspect newborn separate from well	32.4[b]
Sterilization of all milk for newborns	92.2
Average per cent	73.5

a. Hospitals with 25 or more beds.
b. Percentage was low due to fact that sick infants were frequently transferred to pediatric wards or were isolated in private rooms.

In these larger general hospitals there were 32,748 births in hospitals with no house staff; 20 per cent were born in hospitals which did not have a room used exclusively for the preparation of formulae, and approximately 60 per cent were born in hospitals which had no full-term sick or suspect newborn nursery separate from the well-baby nursery.

When compared with other states in respect to newborn infants in hospitals with specified characteristics, Ohio (with 74 per cent) was found to have the eleventh highest average. The highest was Rhode Island with 89 per cent; the lowest, New Mexico with 36 per cent; and the United States average was 71 per cent.

The Very Small Hospitals—The 29 hospitals of fewer than 25 beds had 1.9 per cent of the child admissions, and 4.4 per cent of the hospital births during the report year.

Following is a comparison of facilities in the small and large hospitals. The deficiencies are outstanding.

Per Cent of Hospitals With Specified Characteristics

	Fewer than 25 beds	25 beds or more
Registered by A. M. A.	48.5	92.6
Clinical laboratory in hospital	31.0	80.6
Separate nursery for newborn only	93.1	94.6
Graduate nurse on duty at all times in newborn nursery	71.4	91.1
With pediatric unit[a]	-0-	48.6
Average percentage with specified characteristics	48.8	81.5

a. By definition.

Facilities for the Care of Acute Poliomyelitis—One hundred and forty-four hospitals with 25 or more beds, reported on whether or not poliomyelitis cases were admitted. Of these 24 or 16.7 per cent admitted acute poliomyelitis cases for care, and 32 or 22.2 per cent reported admissions for diagnosis only. The number of cases of acute poliomyelitis reported during the year was 718.

B. SPECIAL HOSPITALS ADMITTING CHILDREN

The relative importance of the special hospital in the care of children is indicated by the fact that during one year there were about 700,000 days of care. Certain special hospitals are not included because schedules were not received from them.

	Number of Hospitals Admitting Children	Days of Child Care
Tuberculosis	8	35,143
Convalescent and Chronic	4	64,586
Orthopedic[a]	2	22,552
Eye, Ear, Nose, and Throat[a]	3	1,466
Mentally Deficient and Epileptic	3	570,967
Contagious Diseases[b]	0	
Nervous and Mental	0	

a. Orthopedic, and eye, ear, nose and throat surgery is also done in general hospitals.
b. Contagious disease units were contained in general and children's hospitals.

C. OUTPATIENT SERVICES FOR CHILDREN

Of the 162 general hospitals caring for children, only 28 operated outpatient departments which

admitted children. These clinics were distributed as follows:

Greater metropolitan	9
Lesser metropolitan	17
Adjacenta	2
Isolated areas	0

a. There was one independent medical clinic in an adjacent county.

The 29 outpatient clinics reported a total of 108,275 child visits during the study year, or 62.5 per 1,000 children, making Ohio the thirteenth ranking State in clinic visits by children.

Only 16 hospitals reported that services were rendered in separate pediatric clinics. In these hospitals, the number of pediatric clinics furnishing specialist service to children was as follows:

Allergy	7	Surgery	6
Cardiology	8	Eye	5
Mental Hygiene	10	Ear, Nose, Throat	5
Luetic	8	Orthopedic	7
Neurology	7	Dentistry	5

SUMMARY

1. The number of beds per 1,000 children in general hospitals was 12.7 in Ohio which was about the average for the United States and less than half for the number in the highest state. Only 10 per cent of the beds in general hospitals were permanently set aside for children.

2. Admissions of children to general hospitals in Ohio totalled 96,068 during the year of study; this gave an annual rate of 55.5 per 1,000 children as compared to 97.3 in the highest state. The rates in the isolated counties were 50 per cent less than in metropolitan-adjacent counties.

3. Of the total amount of care for children in general hospitals in Ohio, 57 per cent was for newborn. At the time of the study there were 4,213 bassinets and 431 incubators in hospitals in the State.

4. Data were obtained from 20 special hospitals admitting children at the time of the study. The number of days of care for children in special hospitals in Ohio was 401 per 1,000 children.

5. Of 56 hospitals admitting poliomyelitis cases for care and/or diagnosis, 41 were located in metropolitan-adjacent counties.

6. There were 28 outpatient departments which admitted children at the time of the study.

INTRASTATE COMPARISONS

Below, the total number of beds per 1,000 children are given according to the various county groupings, and are listed as "Below Average" or "Above Average" of the United States average of 12.8 beds per 1,000 children.

TOTAL BEDS PER 1000 CHILDREN

Below Average		Above Average	
Whole State	12.7		
Counties Classified by Metropolitan Character			
Isolated	7.8	Metropolitan-adjacent	13.8
Counties Classified by Geographical Division			
Group II	11.4	Group I	17.1
Group III	8.4	Group VI	18.1
Group IV	8.7		
Group V	8.7		
Group VII	4.5		
Counties Classified by Per Cent Rural Farm Population			
30 - 39%	7.0	Under 30%	15.0
40 - 49%	5.2		
50% or more	2.6		

It may readily be seen that the majority of the areas had below the average of total number of beds per 1,000 children.

The number of admissions of children to general hospitals during the report year are given below for the various county groupings. The rate for the whole state was 55.5 per 1,000 children. The United States average was 51.4.

ADMISSIONS PER 1,000 CHILDREN

Below Average		Above Average	
		Whole State	55.5
Counties Classified by Metropolitan Character			
Isolated Counties	30.2	Metropolitan-Adjacent	61.0
Counties Classified by Geographical Division			
Group III	36.0	Group I	68.0
Group IV	36.4	Group II	62.8
Group V	38.0	Group VI	77.2
Group VII	18.4		
Counties Classified by Per Cent Rural Farm Population			
30 - 39%	26.8	Under 30%	65.9
40 - 49%	23.8		
50% or more	10.6		

Again it may be noted that the majority of hospital care, as judged by the admission rate, is concentrated in a few areas, in geographic groupings I, II, and VI, and in areas having less than 30 per cent rural farm population.

REFERENCES

8. Cuyahoga, Franklin, Greene, Hamilton, Lake, Lucas, Mahoning, Montgomery, Portage, Stark, Summit, Trumbull, and Wood Counties.
9. Mercer, Morgan, Noble, and Paulding Counties.
10. A county is said to be without medical service if there is not at least one public elementary school in which medical examinations by a physician are done on (a) all pupils once a year, (b) certain grades once a year, or (c) referrals by teachers or nurses.
11. A school physician may be counted more than once if he serves more than one agency. Includes physicians working full or part time in schools.
12. Adults are included by 2 agencies reporting a total of 9,428 immunizations.
13. In this report the term "hospitals" is limited to those caring for children, including the newborn. No institution is included having less than 5 beds for regular inpatient care. Federally owned hospitals are excluded.
14. For the purpose of this report "general" is taken to include maternity and pediatric hospitals.
15. Hospitals (of 25 beds or more) which have 5 or more beds permanently set aside for the care of children.

Stark County Diabetes Drive . . .

Localized Survey Produces Interesting Results as Representative Number of Persons Take Advantage of Doctors' Offer for Free Tests

INTERESTING findings have been reported as a result of the pioneering work done by the Stark County Medical Society in its recent Diabetes Detection Drive. The program, culminating in the Diabetes Detection Week (March 14-19), revealed that of 12,795 persons checked, 478, or 3.7 per cent of the examinations, showed presence of sugar after a heavy carbohydrate meal.

The results are especially interesting because they show that such a drive can be initiated and carried out in a dignified and professional manner through doctors' offices.

The program was initiated last fall when Dr. Charles A. LaMont was requested by the American Diabetes Association to organize a local drive in coordination with the national drive scheduled to be held in December of that year. Dr. LaMont presented the problem to the Council of the Stark County Medical Society, as a result of which a committee was appointed with Dr. LaMont as chairman. Because of the short time before the National Week, the committee decided that it would be better to hold a drive later in the winter.

THROUGH DOCTORS' OFFICES

The American Diabetes Association had recommended that detection centers be set up throughout the city for the purpose of the drive. The Council of the Ohio State Medical Association, however, had recommended that if such a drive were undertaken examinations be conducted in doctors' offices. This same policy was adopted by the Stark County Medical Society and a preliminary check with local doctors showed that more than 90 per cent were willing to conduct free diabetes detection examination in their offices. It was thought that while doing a service to the community this service would help in promoting good will for doctors.

The committee began in November to prepare publicity for the Diabetes Detection Week which was scheduled for March 14-19. Cooperation was good from all groups, officers reported. Druggists of Stark County were contacted and agreed to furnish bottles for urine specimens.

Newspapers and radio stations agreed to cooperate. Newspapers ran a series of front page articles on the subject. Schools—county, city and parochial—passed out small folders which were printed at the expense of the Stark County Medical Society. The Canton Ad Club cooperated by drawing up the folders.

Radio stations presented a series of five-minute talks by local doctors and a 15-minute talk by Dr. Thomas P. Sharkey of Dayton. In addition, each station ran a series of spot announcements before and during the drive.

COOPERATION WIDESPREAD

A number of pharmaceutical firms contributed to the drive by furnishing testing equipment and posters to inform the public about the survey.

Hospital laboratories and private laboratories agreed to do free blood sugars on those persons found to be positive on recommendation of physicians who make initial checks.

As an opening kickoff for the Diabetes Detection Week, the committee invited Dr. Sharkey to speak before the Stark County Medical Society. Dr. Sharkey had conducted a successful drive in Dayton and Montgomery County.

Results of the survey were fairly satisfactory in the opinion of committee members. There were a total of 12,795 persons checked, with 478 or 3.7 per cent showing presence of glycosuria after a heavy carbohydrate meal. The survey group did not collect figures on those that were later verified as having true diabetes mellitus as that was considered a matter between patient and physician, and in most cases such a study would require time for proper evaluation.

192 DOCTORS PARTICIPATE

The committee reported that 192 doctors out of a total of 271 sent in reports. Considering the number of those who were limited specialists without facilities to do urine testing, and those in non-practicing positions, the committee felt that cooperation among doctors was close to 100 per cent.

"While the actual number of people taking advantage of the doctors' offer was not too high, we feel that the program was a success in many ways," the committee reported. "Many people appreciated the doctors' offer of their services and at least one of the labor organizations wrote a letter of appreciation to the Medical Society. At this time we feel it did help to cement the doctor-patient relationship and feeling of good will in the community," the report concluded.

Proceedings of The Council . . .

Official Business Transacted At Dinner Meeting on Eve of 1949 Annual Meeting; Policies on Educational and Legislative Matters Established

A REGULAR meeting of The Council of the Ohio State Medical Association was held on the evening of Monday, April 18, 1949, at the Neil House, Columbus, Ohio. This followed a dinner and was on the eve of the 1949 Annual Meeting. All members of The Council, except Dr. Dixon, were present, and in addition a number of guests including A. M. A. delegates, chairmen of standing committees and of local committees on arrangements.

The minutes of the last meeting of The Council held on February 27, 1949, were **approved,** on **motion** duly made, seconded and unanimously **carried.**

Membership statistics reported by the Executive Secretary were as follows: Total membership as of April 18, 1949, 7,143; compared to a total membership of 7,331, as of December 31, 1948.

The annual audit of the books of the Association and *The Journal* by Keller, Kirschner, Martin & Clinger, certified public accountants, Columbus, was presented and **approved** on **motion** duly made, seconded and unanimously **carried.**

A. M. A. ASSESSMENT

A report on the collection of the A. M. A. assessment in Ohio was presented. On **motion** duly made, seconded and unanimously **carried,** the incoming President, Dr. Lincke, was instructed to send a letter to all members who have not paid the A. M. A. assessment, reminding them of this obligation and requesting them to pay the assessment promptly. The same motion instructed the Executive Secretary to prepare a list of the members who have not paid the A. M. A. assessment and that such list be submitted to the president and secretary of each county medical society with a request for local follow-up.

EDUCATION COMMITTEE REPORT

The Council received a report from the Committee on Education, recommending that the Association not adopt a recommendation that at least five years of general practice be required before a physician would be eligible to enter training for a medical specialty. On **motion** duly made, seconded and unanimously **carried,** the report was amended and it was then adopted by The Council, as amended, with a recommendation that it be submitted to the House of Delegates on the following day.

V. A. PROPOSAL

The Council then considered a report from the Committee on Medical Care of Veterans with respect to certain changes in the medical and surgical fee schedule which is a part of the agreement between the Ohio State Medical Association and the Veterans Administration. On **motion** duly made, seconded and unanimously **carried,** the recommendations of the majority of the members of the committee were **approved,** with minor exceptions, in which event The Council indicated the recommended fees and instructed the Executive Secretary to communicate as promptly as possible with the Veterans Administration on this matter setting forth the suggestions of The Council.

A communication from the Tennessee Medical Society, making certain suggestions for revisions in the Veterans Administration laws and regulations, was discussed and, on **motion** duly made, seconded and unanimously **carried,** was referred to Ohio's delegates to the American Medical Association for consideration and any action which they deemed necessary.

HEART PROGRAM

A communication from the Central Ohio Heart Association, which had been requested by The Council, summarizing the activities of that organization and its basic policies, was reviewed very thoroughly. After a thorough discussion, The Council, on **motion** duly made, seconded and unanimously **carried, adopted** the following resolution:

"First, that the principles and policies as outlined in the communication, signed by Dr. R. W. Kissane, Columbus, be approved in principle;

"Second, that the program should not be placed in effect in any county until it has had the approval of the county medical society."

LEGISLATION

There was a discussion of a new bill introduced in the Congress, namely S. 1456, sponsored by Senator Hill of Alabama. The Council took no action pending further study of the measure.

A resolution pertaining to Federal legislation and other matters relating to the issue of com-

pulsory sickness insurance was adopted by The Council by an unanimous vote with a recommendation that it be referred to the House of Delegates on the following day for consideration and action.

MISCELLANEOUS BUSINESS

A proposal from the American Legion, that efforts be made to have physicians purchase a supply of the "Freedom Booklets" issued by the Legion for display in their offices or for patients, was discussed. On **motion** duly made, seconded and unanimously **carried**, the Executive Secretary was instructed to advise the members about the booklets and to send literature concerning them, leaving it up to each individual physician to decide the matter of purchasing the booklets.

A communication from Mrs. Elizabeth P. August, Secretary of the Ohio State Nurses' Association, asking representation from the Ohio State Medical Association on a committee which is considering the Brown report on "Nursing for the Future," was read. On **motion** duly made, seconded and unanimously **carried**, the incoming President was authorized to serve as a member of such advisory committee, or to name a proper alternate.

A communication, asking the Association to purchase a transcript of proceedings of the National Conference on Medical Service, was considered. By official action the Executive Secretary was instructed not to purchase such a transcript.

On **motion** duly made, seconded and unanimously **carried**, the Auditing and Appropriations Committee was authorized to approve the expenditure of a reasonable amount of money for the purchase of golf prizes for the Ohio State Medical Association Golfers' Association.

The Council, on **motion** duly made, seconded and unanimously **carried**, approved House Bill 444, which provides stringent penalties for persons advertising themselves as members of the profession when they are not licensed to practice such profession.

The President, by official action of The Council, was authorized to appoint a committee to judge the scientific exhibits at the 1949 Annual Meeting. There was a discussion regarding the A. M. A. general practitioner's award and the matter of selection of an Ohio candidate for such award. Reference was made to the recent statement in the *American Academy of General Practice Bulletin* on this matter. After taking all angles into consideration, The Council, on **motion** duly made, seconded and unanimously **carried**, decided that the Association should not at this time take any action toward selecting an Ohio candidate.

A communication from Dr. John D. Porterfield, Director of Health, outlining a state-wide venereal disease educational program to be conducted during the months of July and August, was received and reviewed. On **motion** duly made, seconded and unanimously **carried**, The Council approved the program in principle.

The Executive Secretary was instructed by The Council to send a telegram to Dr. Harry V. Paryzek, Cleveland, former president, who is ill, wishing him a speedy recovery.

Dr. Brindley, the President, thanked The Council for its splendid work during the year and extended on behalf of The Council thanks to Dr. Rutledge and Dr. Messenger, retiring members of The Council.

On **motion** duly made and **adopted** by a standing vote, The Council expressed appreciation to Dr. Brindley and congratulated him on a very successful term of office as president.

There being no further business, The Council recessed to meet with the House of Delegates on the following day.

SPECIAL MEETING OF THE COUNCIL

A special meeting of The Council of the Ohio State Medical Association called by the incoming President, Dr. Carl A. Lincke, was held on Thursday afternoon, April 21, at the Deshler-Wallick Hotel, Columbus, Ohio.

Dr. D. W. Heusinkveld, Cincinnati, newly elected Councilor, submitted his resignation as a member of the Committee on Public Relations and Economics. The Council by official action, on **motion** duly made, seconded and unanimously **carried**, appointed Dr. H. B. Wright, Cleveland, to serve the unexpired term of Dr. Heusinkveld on this committee.

The Council then by official action confirmed the following committee appointments made by President Lincke:

Auditing and Appropriations—Dr. Fred W. Dixon, Cleveland, chairman; Dr. Carll S. Mundy, Toledo; Dr. H. M. Clodfelter, Columbus.

Committee on Cancer—Dr. C. E. Hufford, Toledo, chairman; Dr. John H. Lazzari, Cleveland; Dr. Carl A. Wilzbach, Cincinnati; Dr. L. A. Pomeroy, Cleveland; Dr. Robert M. Zollinger, Columbus; Dr. Robert T. Allison, Jr., Akron; Dr. E. P. McNamee, Cleveland; Dr. W. D. Nusbaum, Lancaster.

Committee on Industrial Health and Workmen's Compensation—Dr. H. P. Worstell, Columbus, chairman; Dr. F. G. Barr, Dayton; Dr. Geo. F. Sykes, Cleveland; Dr. Robert A. Kehoe, Cincinnati; Dr. Louis N. Jentgen, Columbus; Dr. John M. Van Dyke, Canton; Dr. James N. Wychgel, Cleveland; Dr. Warren A. Baird, Toledo; Dr. A. L. Bershon, Toledo.

Subcommittee on Legislation—Dr. G. A. Woodhouse, Pleasant Hill, chairman; Dr. Emil R. Swepston, Cincinnati; Dr. Floyd M. Elliott,

Ada; Dr. D. J. Slosser, Defiance; Dr. David M. Keating, Cleveland; Dr. Wm. M. Skipp, Youngstown; Dr. Jay W. Calhoon, Uhrichsville; Dr. R. G. Plummer, Newark; Dr. Clyde M. Fitch, Portsmouth; Dr. Donald F. Bowers, Columbus; Dr. George F. Linn, Norwalk.

Committee on Medical Service Plans—Dr. Robert C. Rothenberg, Cincinnati, chairman; Dr. Wm. M. Skipp, Youngstown; Dr. Jonathan Forman, Columbus; Dr. R. K. Finley, Dayton; Dr. Robert E. S. Young, Columbus; Dr. Carll S. Mundy, Toledo; Dr. Reyburn McClellan, Xenia; Dr. Azel Ames, Jr., Hamilton; Dr. Farrell T. Gallagher, Lakewood.

Committee on Mental Hygiene—Dr. Dwight M. Palmer, Columbus, chairman; Dr. Neil McDermott, Cleveland; Dr. Louis J. Karnosh, Cleveland; Dr. Maurice Levine, Cincinnati; Dr. Milton Rosenbaum, Cincinnati; Dr. R. E. Pinkerton, Akron; Dr. O. M. Lawton, Youngstown; Dr. J. L. Sagebiel, Dayton; Dr. Elmer Haynes, Toledo; Dr. Frank F. Tallman, Columbus.

Committee on National Emergency Medical Service—Dr. C. C. Sherburne, Columbus, chairman; Dr. Robert Conard, Wilmington; Dr. Cyrus R. Wood, Port Clinton; Dr. Carl R. Damron, Mansfield; Dr. Robert M. Zollinger, Columbus; Dr. Harry R. Huston, Dayton; Dr. W. O. Ramey, Cincinnati; Dr. Richard L. Meiling, Columbus; Dr. E. A. Ockuly, Toledo; Dr. Claude S. Perry, Columbus; Dr. Drew L. Davies, Columbus; Dr. Robert E. Tschantz, Canton; Dr. Maurice M. Kane, Greenville; Dr. Fred Berlin; Lima; Dr. William J. Graf, Cincinnati; Dr. W. C. McCally, Cleveland.

Committee on Rural Health—Dr. Carll S. Mundy, Toledo, chairman; Dr. Jonathan Forman, Columbus; Dr. W. B. Recker, Leipsic; Dr. E. G. Caskey, Mineral Ridge; Dr. Wm. B. Taylor, Jackson; Dr. James M. Snider, Marysville; Dr. H. T. Pease, Wadsworth; Dr. A. D. Harvey, Lebanon; Dr. L. E. Anderson, Greentown; Dr. H. R. Mayberry, Bryan; Dr. Edmond K. Yantes, Wilmington; Dr. J. Martin Byers, Greenfield; Dr. F. M. Hartsook, Cardington; Dr. Carl Goll, Hopedale.

Committee on School Health—Dr. Thomas E. Shaffer, Columbus, chairman; Dr. Carl A. Wilzbach, Cincinnati; Dr. J. W. Wilce, Columbus; Dr. C. W. Wyckoff, Cleveland; Dr. Charles T. Atkinson, Middletown; Dr. L. A. Hamilton, Athens; Dr. T. L. Light, Dayton; Dr. R. E. Shell, Van Wert; Dr. John F. Miller, Newark; Dr. Margaret O'Neal, Zanesville; Dr. F. A. Halloran, Springfield; Dr. H. B. Thomas, Gallipolis; Dr. Russell C. Bane, Chillicothe; Dr. J. M. Painter, Kent.

Committee on Medical Care of Veterans—Dr. Drew L. Davies, Columbus, chairman; Dr. Robert Conard, Wilmington; Dr. Harry R. Huston, Dayton; Dr. Wm. W. Trostel, Piqua; Dr. W. W. Green, Toledo; Dr. Edgar Northrup, Marietta; Dr. John H. Marshall, Findlay; Dr. Ivan C. Smith, Youngstown; Dr. Lewis W. Cellio, Columbus; Dr. Charles L. Shafer, Mansfield; Dr. L. D. Allard, Portsmouth; Dr. Robert L. Eastman, Mt. Vernon; Dr. E. H. Crawfis, Cleveland; Dr. T. H. Vinke, Cincinnati.

Woman's Auxiliary Advisory Committee—Dr. H. M. Clodfelter, Columbus, chairman; Dr. Paul A. Davis, Akron; Dr. Chester P. Swett, Lancaster.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

If Also for That Purpose, Bond Issue Must Specify Hospital Equipping

No part of the proceeds of bonds issued for the purpose of building a hospital may be used for equipping it, unless the purpose of the issue so states. In at least one instance in Ohio, authorities issued bonds with the intention of building and equipping a hospital, but failed to specify the equipping angle.

The syllabus of a recent opinion by Attorney General Herbert S. Duffy on the subject is as follows: "Where a county issues bonds for the purpose of acquiring a site and erecting a building for a county hospital and the proceedings of the bond issuing authority prior to the submission of the question of the issuance of such bonds to the electors of the county and the ballot used at the election thereon state the purpose of the issue to be 'acquiring a site and erection of a building for a county hospital,' no part of the proceeds from the sale of bonds issued pursuant to such proceedings may be used for the purpose of equipping such hospital." Opinion No. 392.

Another opinion on the subject of hospitals is as follows: "A county is not permitted to vote a special tax levy for maintenance of a county hospital outside of the ten mill limitation under Secs. 3127 to 3138-4, G. C., An additional tax for such purpose may be submitted to the electors under Sec. 5625-15, G. C., and related sections." Opinion No. 365.

For 12 years U. S. physicians' collection percentages have gotten steadily better, according to a survey conducted by *Medical Economics* and reported in its May issue. In 1947 the average doctor received payment on 88 per cent of his bills. In 1935, the magazine reports, the average independent physician collected 74 per cent of his bills. The percentage jumped to 78 per cent in 1939, 87 per cent in 1943 and 88 per cent in 1947. Full specialists collected 90 per cent of their bills while general practitioners averaged 87 per cent.

House of Delegates . . .

Official Proceedings of Sessions Held During 1949 Annual Meeting in Columbus, April 19-22; New Officers, Councilors and Committeemen

MINUTES OF FIRST SESSION

THE first session of the House of Delegates, held in conjunction with the 1949 Annual Meeting of the Ohio State Medical Association, convened in the Hall of Mirrors, Deshler-Wallick Hotel, Columbus, Ohio, on Tuesday evening, April 19, 1949, following a complimentary dinner for all delegates.

The meeting was called to order by Dr. Gilman D. Kirk, President of the Columbus Academy of Medicine. Dr. Kirk welcomed the delegates to Columbus and then introduced Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association. Dr. Brindley then presented his presidential address. **(See page 613 this issue for text of address.)**

The roll of delegates was called by the Executive Secretary, 126 certified delegates or alternates answering the roll call.

On motion duly made, seconded and unanimously carried, the minutes of the sessions of the House of Delegates held at the 1948 Annual Meeting in Cincinnati were approved.

REFERENCE COMMITTEES APPOINTED

Dr. Brindley appointed the following reference committees to consider business coming before the House of Delegates and for reports back to the House:

Resolutions—G. A. Woodhouse, Pleasant Hill, chairman; C. T. Atkinson, Middletown; Frank M. Wiseley, Findlay; G. A. Boon, Oak Harbor; H. B. Wright, Cleveland; Wm. M. Skipp, Youngstown; Samuel Weir, Minerva; George C. Malley, Zanesville; W. R. Swango, Ironton; Grant O. Graves, Columbus; N. P. Stauffer, Millersburg.

President's Address—O. E. Todd, Toledo, chairman; F. P. Berlin, Lima; L. E. Anderson, Greentown; A. W. Carley, Dayton; Edward J. McGrath, Cincinnati.

Time and Place of Annual Meeting—Roy E. Shell, Van Wert, chairman; D. J. Slosser, Defiance; E. V. Arnold, Delaware; R. F. Fasoli, Brunswick; E. J. Wenaas, Youngstown.

Credentials—Carl F. Goll, Hopedale, chairman; D. C. Houser, Urbana; R. E. Pinkerton, Akron; Paul H. Jones, Stockdale.

Tellers and Judges of Election—J. Martin Byers, Greenfield, chairman; Kenneth E. Bennett, Marietta; H. L. Keiser, Fremont; Kurt Weidenthal, Hudson; Edmond K. Yantes, Wilmington.

The next order of business was the nomination and election of a Committee on Nominations.

NOMINATING COMMITTEE ELECTED

The following delegates were nominated and duly elected to the Committee on Nominations:

First District—D. W. Heusinkveld, Cincinnati.
Second District—J. E. Gillette, Versailles.
Third District—Fred P. Berlin, Lima.
Fourth District—Albert L. Bershon, Toledo.
Fifth District—Fay A. LeFevre, Cleveland.
Sixth District—Wm. M. Skipp, Youngstown.
Seventh District—Carl F. Goll, Hopedale.
Eighth District—George A. Gressle, Newark.
Ninth District—Earl J. Levine, Wellston.
Tenth District—Ralph W. Holmes, Chillicothe.
Eleventh District—Ross M. Knoble, Sandusky.

RESOLUTIONS INTRODUCED

The President then called for the introduction of resolutions. The first resolution was submitted by the Executive Secretary on behalf of The Council. He also submitted a report of the Committee on Education which had been amended and approved by The Council and ordered submitted to the House of Delegates. The President ruled that this was in effect a resolution. Three resolutions were presented by Dr. A. L. Bershon, Toledo, on behalf of the Toledo Academy of Medicine. The final resolution was presented by Dr. Edmond K. Yantes, Wilmington, on behalf of the Clinton County Medical Society. All of these items were referred without debate to the Reference Committee on Resolutions.

(See Minutes of Second Session of House of Delegates for texts of resolutions and action on them by the House of Delegates.)

INVITATION FROM COLUMBUS

At this point, on behalf of the Columbus Academy of Medicine, Dr. Kirk presented an invitation to the Association to hold its 1952 Annual Meeting in Columbus. The invitation was referred to the Reference Committee on Time and Place of Annual Meeting. Dr. Brindley announced at this point that the 1950 Annual Meeting would be held in Cleveland the week of May 14, and that the 1951 Annual Meeting would be held in Cincinnati the week of April 22, in accordance with action of the House of Delegates at the 1948 Annual Meeting.

AMENDMENT TO BY-LAWS

Under the item of new business, the Executive Secretary presented to the House of Dele-

gates a proposed amendment to the Constitution and By-Laws which had been held over from the 1948 Annual Meeting and which had been published in *The Journal* in accordance with the Constitution and By-Laws.

Following is the text of the proposed amendment:

> "In Chapter 8, Section 7, of the By-Laws, relating to the filling of vacancies in office by The Council, delete the last sentence reading as follows: 'The appointee shall serve until his successor has been elected and qualified' and substitute in lieu thereof the following: 'The appointee shall serve until the next Annual Meeting of the House of Delegates at which time the office shall be filled as provided for in the Constitution and By-Laws.' "

On motion duly made, seconded and unanimously carried, the above amendment to Chapter 8, Section 7, of the By-Laws was adopted.

There being no further business, the House of Delegates recessed until Thursday noon, April 21.

MINUTES OF SECOND SESSION

The second session of the House of Delegates was called to order by President Brindley at 1:15 p. m., April 21, 1949, in the Hall of Mirrors, Deshler-Wallick Hotel, Columbus.

The roll call showed 123 certified delegates or alternates in attendance.

Dr. Brindley called for reports of the reference committees. The first committee to report was the Reference Committee on President's Address, presented by Dr. O. E. Todd, Toledo, chairman of that committee. The report read as follows:

REPORT ON PRESIDENT'S ADDRESS

"The Committee on President's Address, after due deliberation on the accomplishments and objectives of the Ohio State Medical Association discussed in the address of Dr. Brindley, wishes to submit the following report:

"The acknowledgment by Dr. Brindley that our Ohio State Medical Association is a mature organization that functions as a unit behind its officers speaks well for his able leadership during the past year. This solidarity of action should be continuously fostered and cherished in years to come. It will be noted that other state medical societies and many organizations and groups outside the medical profession have sought our counsel and guidance. The chronological review of some of the milestones in medical legislation and medical public relations during the past few years emphasizes the vital importance of unified action, 'Time Marches On' is a most appropriate title for the President's Address.

"It is to be noted from the President's Address that the 25-point program adopted in 1945 is being aggressively carried forward toward ultimate completion. This is exemplified by the way in which the Association's Committee on Rural Health has advanced the cause of preventive medicine and improved public relations of the medical profession of Ohio.

WOMAN'S AUXILIARY

"Dr. Brindley justifiably compliments the Woman's Auxiliary of the Ohio State Medical Association upon their remarkable progress during the past year. The paid-up membership of approximately 3,100 would seem to indicate the excellence of its leadership. Some of the vitally important activities of the Auxiliary including nurse recruitment, public relations and health education are mentioned briefly. We should continue to give our undivided support to this very worth-while organization.

PUBLIC RELATIONS AND EDUCATION

"Dr. Brindley emphasizes repeatedly in his Address the continued importance of our public relations department and points out how it has expanded since its inception ten years ago. It cannot be denied that today it is one of our greatest assets. Under the direction of Scottie Saville, assisted by Hart Page, it speaks for organized medicine. Through many excellent pamphlets distributed to thousands not only in Ohio but also in other parts of the country the people have been and continue to be told about the things for which the medical profession stands. Recommendations are being made for activities which can be carried out in any community to improve the health of all citizens. It is again brought to our attention that the three basic channels for molding public opinion in Ohio are (1) The Ohio State Medical Association, (2) The County Medical Society and (3) The Individual Physician.

THE STATE ASSOCIATION

"Dr. Brindley points out the excellence of our Ohio State Medical Association and again brings to our attention that all members can be well informed at all times if they will but take the time and trouble to read the *OSMAgram*, State Journal, bulletins, personal communications, etc. It is emphasized that no state medical society of the country presents to its membership in more detail or with more dispatch, reports on its activities. Dr. Brindley points out quite correctly that the State Association exists for the members and not the members for the Association, and at the same time, acts as spokesman for organized medicine.

"Your committee wishes to re-emphasize the importance of our capable and outstanding executive secretary, Chuck Nelson, and pay tribute to his loyal service. His activities with respect to the administrative phases of our medical organization, together with his genius for organizing our activities, will continue to be an inspiration in the future as in the past. His is truly a vital part of our State Association.

THE COUNTY MEDICAL SOCIETY

"Our President points out that the County Society represents an important organization in the community and as such has definite obligations to fulfill and untold opportunities for promotion of good will among the public. The local society is responsible for disciplinary action against those members whose actions bring discredit not only upon themselves, but also upon the profession as a whole. Courageous

action on the part of each county medical society is necessary to maintain the good will and esteem of the public. Dr. Brindley points out that we must bring about definite improvement in the service rendered the public and in so doing will eliminate the basis for some of the charges which are being hurled at the medical profession by those who are demanding the government take over our entire system of medical practice.

THE INDIVIDUAL PHYSICIAN

"Dr. Brindley criticizes some of the individual physicians, pointing out that poor public relations on the part of one individual makes for poor public relations for the profession as a whole. He justifiably states that his criticism of individual doctors is presented only as a constructive effort to correct what he feels to be a glaring defect and in the hope of stimulating action on a matter which is causing the profession great harm. We are sure that Dr. Brindley is sincere in his belief that only through the concerted efforts of the individual physician can our fight against the move to socialize our profession be won and unhesitatingly endorse this philosophy.

LOOK AT THE FUTURE

"Dr. Brindley takes a thoughtful look at the future more by inference than actual statement. The title of his address 'Time Marches On' should make us pause for a moment and ask ourselves what we, as individual practitioners of the healing art, can do to eliminate the ever present demand for socialized control of our system of medical practice. The future of our profession and the future of the health of the nation depend upon the answer, and upon improvement in the services rendered to the public. We must give the American people the best product at the best price and as is pointed out, it is imperative that we maintain a system which has fostered individual initiative and has provided an incentive to each physician to do better work.

CONCLUSION

"In his concluding remarks, Dr. Brindley states 'Time marches on—but not alone. We too must go on. Let us so live each day that we may be better doctors, better citizens, better men and women.' Your committee recognizes the wisdom of this concluding statement.

"We feel that the address of Dr. Brindley should be an inspiration to all of us and the constructive criticism included therein taken to heart by those concerned. It represents a thoughtful review of the ever-changing aspects of medical practice and public relations as they exist today."

On motion duly made, seconded and unanimously carried, the report of the Reference Committee on President's Address was adopted.

ACTION ON RESOLUTIONS

Dr. G. A. Woodhouse, Pleasant Hill, chairman, of the Reference Committee on Resolutions, then submitted the following report:

"The Reference Committee on Resolutions has reviewed the six resolutions introduced in the first session of the House of Delegates and referred to this committee. Several members interested in the various resolutions appeared and testified before the committee. The recommendations of the Committee on the resolutions are as follows:

RESOLUTION A

"This resolution was submitted to the House of Delegates on behalf of The Council. It read as follows:

"We, the House of Delegates of the Ohio State Medical Association, composed of duly elected representatives of the Association's 88 component county medical societies, with an aggregate membership of approximately 7,400 doctors of medicine, in annual session in Columbus, Ohio, April 19-22, 1949, officially endorse the following statement of policy with respect to proposals and programs dealing with the health of the people of Ohio and the nation at large:

"1. We re-endorse the Twenty-Five Point Health Program for Ohio, adopted by the House of Delegates of this Association on May 6, 1946. This program pledges the facilities and active support of the medical profession to sound and constructive activities to find solutions for problems in the following fields: Economic improvement, improved housing, malnutrition, sanitation, smoke abatement, communicable diseases, venereal diseases, tuberculosis control, health education, physical examinations, cancer and chronic diseases, mental diseases, rehabilitation of the handicapped, recreation facilities, school health, industrial health, medical care of the needy, state and local health department services, maternal and child health services, hospital facilities, prepaid medical care plans, prepaid hospital care plans, care of the disabled veterans, rural health, and medical education.

"2. We endorse the new Twelve-Point Program of the American Medical Association, which charts for the nation activities which parallel those enumerated above. We pledge the active support of the Ohio State Medical Association to positive programs which are being launched to achieve the objectives of the A. M. A. program.

"3. We endorse the action of the House of Delegates of the American Medical Association in requesting members to make a financial contribution to a nation-wide public educational campaign and urge all members of the Ohio State Medical Association to pay the $25.00 A. M. A. per capita assessment which has been levied for that purpose.

"4. We endorse and support, particularly, efforts being made to bring about rapidly the further development and wider coverage of those voluntary medical and hospital insurance plans which will provide the people of Ohio, and elsewhere, with good protection against the costs of illness.

"5. We endorse in principle, and will support, properly drafted legislation, state and national, which may be deemed necessary to carry out the recommendations of the programs of the Ohio State Medical Association and the American Medical Association.

"6. We are opposed to proposals which would establish a national or state system of political medical or hospital care. Specifically, we are opposed to any system of

compulsory sickness or health insurance. We pledge the Association to efforts to defeat such legislation now pending in the Congress and similar measures which may be introduced at any future time.

"7. We are confident that the benefits of modern medical and health services can be made available to all Americans through the initiation and development of voluntary programs and through safe and sane activities of governmental agencies in fields which are the proper function and responsibilities of government. On the other hand, we are convinced that costly, compulsory, bureaucratic, political schemes will force the American people to accept substandard medical and health services, the inevitable result of state socialism which experiences in other nations confirm.

"Your committee heartily approves of this resolution and recommends that it be adopted."

On motion duly made, seconded and carried, with only one dissenting vote, the recommendation of the committee, namely, that Resolution A be adopted, was approved.

RESOLUTION B

"The second matter referred to the committee consisted of a report submitted to The Council by the Committee on Education; approved by The Council with minor amendments and submitted to the House of Delegates for consideration.

"The report, as submitted, read as follows:

"A proposal which would require every doctor to engage for five years in general practice before being permitted to enter training for a medical specialty has been referred to the Committee on Education.

"The principal concepts underlying this proposal seem to be (1) that early specialization has deprived certain areas of the services of physicians engaging in general practice, and (2) that any physician would have a broader and more well rounded background if he had engaged in general practice before engaging in specialized practice.

"Assuming this interpretation to be correct, the Committee agrees that a valid problem exists. The Committee wishes to point out, however, the adoption of such a measure would mean that hardly any specialist could hope to enter his chosen field before the age of 35, and that there are numerous practical difficulties—enforcement to mention only one. The Committee believes that some of the basic problems involved are gradually being solved. Solution to others of national scope is being sought through the studies of the intern-resident problem, the constant revision of requirements of the American Specialty Boards, through economic surveys, and through the actions of such organizations as the Committee on Rural Health of the American Medical Association and the Association of American Medical Colleges, all of which are directly or indirectly concerned with the fundamental problems at which this proposal is aimed.

"In the opinion of this committee, a requirement of five years of general practice before entering a specialty would probably be ineffective and is inexpedient educationally at this time. Therefore, the Committee on Education believes that it would be unwise for the House of Delegates to adopt a recommendation of that kind at this time.

"There was considerable discussion before the committee on the subject covered by the foregoing report. Your committee agrees with the statement made in the report that a valid problem exists. At the same time, your committee agrees with the concluding paragraph of the report. Moreover, your committee feels that positive steps have been started here in Ohio as well as on a national basis to try to find solutions for this problem. For example, the Committee on Rural Health and the Committee on Education have had conferences with the officials of Ohio's medical schools on the matter of establishing courses of instruction for general practice and for other types of programs designed to encourage physicians to enter general practice, especially in communities where there is a need for additional general practitioners. The Committee on Rural Health has set up a series of special lectures on the procedures and problems of general practice in small communities. These will be offered to the three Ohio medical schools, together with suggestions for speakers competent to cover the subjects of the lectures.

"In addition, the Committee on Rural Health, with the approval of The Council, is offering medical school scholarships to be awarded to students coming from rural areas and who have a desire to return to such areas for active practice. At the present time both committees have under consideration the possibilities of working out a plan whereby upper class medical students would have an opportunity to serve an externship with physicians in general practice. When details have been developed this proposal will be presented to the medical schools of Ohio for consideration.

"Therefore, your Committee on Resolutions, after taking all of these matters into consideration, recommends that the House of Delegates approve the amended report submitted by The Council."

On motion duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that the amended report submitted by The Council be adopted, was approved.

RESOLUTION C

"This resolution, reading as follows, was presented on behalf of the Toledo Academy of Medicine by Dr. A. L. Bershon:

"Whereas, The Ohio Department of Health because of insufficient funds is not performing the services of an up-to-date health department, and

"Whereas, The citizens of Ohio should be afforded modern public health services, and

"Whereas, The Ohio Department of Health is dependent upon the Federal Government for a large percentage of its funds, and

"Whereas, Ohio, a wealthy state, appropriated only 9.9 cents per capita for public health as against an average of 50.4 cents per capita of the forty-eight states in 1948, Now therefore

"Be it resolved, That the Ohio State Medical Association recommends that the General Assembly of Ohio appropriate sufficient funds to enable the Ohio Department of Health to carry on a full program without depending upon Federal Funds.

"It is recommended that the House of Delegates approve the resolution as presented."

On motion duly made, seconded and unanimously carried, the recommendation of the committee, namely that Resolution C be adopted, was approved.

RESOLUTION D

"This resolution also was presented by Dr. Bershon on behalf of the Toledo Academy of Medicine. It read as follows:

"Whereas, Violations of the Medical Practice Act are still prevalent in the State of Ohio, and

"Whereas, The health and safety of our citizens are jeopardized by any violation of this Act, and

"Whereas, Adequate vigilance by Inspectors of the State Medical Board is the most effective means of enforcing the Medical Practice Act, and

"Whereas, It is impossible for the State Medical Board with its present budget to employ the needed additional inspectors, now, therefore

"Be it resolved, That the Ohio State Medical Association request the Ohio General Assembly to provide the State Medical Board with funds sufficient to employ additional inspectors.

"Your committee recommends its adoption."

On motion duly made, seconded and unanimously carried, the recommendation of the committee, namely, that Resolution D be adopted, was approved.

RESOLUTION E

"Dr. Bershon presented a third resolution on behalf of the Toledo Academy of Medicine, reading as follows:

"Whereas, Membership and Fellowship Classifications in the American Medical Association have led to much confusion on the part of physicians, now, therefore,

"Be it resolved, That the House of Delegates of the Ohio State Medical Association, place itself on record as favoring a single membership classification of the American Medical Association.

"Be it further resolved, That this resolution be presented to the House of Delegates of the American Medical Association in Atlantic City, June 6-10th, 1949.

"The Committee on Resolutions recommends that this resolution be adopted."

On motion duly made, seconded and unanimously carried, the recommendation of the committee, namely, that Resolution E be adopted, was approved.

RESOLUTION F

"Resolution F was presented by Dr. E. K. Yantes on behalf of the Clinton County Medical Society. It read as follows:

"Whereas, A critical shortage of medical officers to serve with the Armed Forces will develop by July of this year, and

"Whereas, The Secretary of Defense repeatedly has given notice to the medical profession that unless this dangerous situation is met by voluntary action a selective draft of physicians will be necessary, and

"Whereas, Many physicians deferred from military service to complete their education wholly or in part at Government expense with an obligation to serve at least two years after graduation have chosen to ignore this obligation, and

"Whereas, The honor of the medical profession is at stake in this and the tradition of patriotic service in the past would be broken by a compulsory selective draft of physicians.

"Therefore be it resolved, That the Ohio State Medical Association request and urge each component Society to review its membership and in case any member is found who is evading his obligation after all means of persuasion have been used, such member be suspended until he has completed his period of service and be it further resolved that the names of such members be certified to the State Board of Medical Examiners with recommendation for suspension of license to practice in Ohio until his obligation to the Government has been fulfilled.

"After careful study of this resolution and hearing discussions by a number of members, the Committee on Resolutions recommends that this resolution be approved with the following amendment: That the concluding paragraph of the resolution be deleted and that the following paragraph be substituted in lieu thereof:

"Therefore be it resolved:

"1. That the House of Delegates endorses and approves the recent action of The Council requesting county medical societies to interview physicians, who were deferred from military service to complete their medical education, for the purpose of urging them to volunteer immediately for service with the Armed Forces.

"2. That the House of Delegates recommends to the authorities of all Ohio hospitals that they encourage members of their intern and resident staffs, who were deferred for the reason stated above, to offer their services to the Armed Forces and that written assurance be given to those volunteering that their hospital appointments will be available upon completion of their military service.

"3. That a copy of this resolution and a copy of the communication forwarded to

county medical societies be sent to the proper officials of all Ohio hospitals."

During the discussion of Resolution F it was moved and seconded that the third paragraph of the resolution be amended to read as follows:

"Whereas, Many physicians deferred from military service to complete their education wholly or in part at Government expense have chosen to ignore their moral obligation to their country, and"

The motion to amend was approved.

On **motion** duly made, seconded and unanimously **carried**, the recommendation of the committee, namely that Resolution F, as amended, be adopted, was **approved.**

The resolution, as approved by your House of Delegates, therefore, read as follows:

AMENDED RESOLUTION F

"Whereas, A critical shortage of medical officers to serve with the Armed Forces will develop by July of this year, and

"Whereas, The Secretary of Defense repeatedly has given notice to the medical profession that unless this dangerous situation is met by voluntary action a selective draft of physicians will be necessary, and

"Whereas, Many physicians deferred from military service to complete their education wholly or in part at Government expense have chosen to ignore their moral obligation to their country, and

"Whereas, The honor of the medical profession is at stake in this and the tradition of patriotic service in the past would be broken by a compulsory selective draft of physicians.

"Therefore be it resolved:

"1. That the House of Delegates endorses and approves the recent action of The Council requesting county medical societies to interview physicians, who were deferred from military service to complete their medical education, for the purpose of urging them to volunteer immediately for service with the Armed Forces.

"2. That the House of Delegates recommends to the authorities of all Ohio hospitals that they encourage members of their intern and resident staffs, who were deferred for the reason stated above, to offer their services to the Armed Forces and that written assurance be given to those volunteering that their hospital appointments will be available upon completion of their military service.

"3. That a copy of this resolution and a copy of the communication forwarded to county medical societies be sent to the proper officials of all Ohio hospitals."

On **motion** duly made, seconded and unanimously **carried**, the report of the Reference Committee on Resolutions as a whole, and as amended by action of the House of Delegates, was **approved.**

COLUMBUS SELECTED FOR 1952

The report of the Reference Committee on Time and Place of the 1952 Annual Meeting was made by Dr. Roy E. Shell, Van Wert. The committee recommended that the invitation of the Columbus Academy of Medicine to hold the 1952 Annual Meeting in Columbus be accepted and that the meeting be held in the spring of the year.

On **motion** duly made, seconded and unanimously **carried**, the recommendation of this reference committee was **approved.**

DR. SWARTZ NAMED PRESIDENT-ELECT

President Brindley announced that the next order of business would be the nomination and election of a President-Elect and he called for nominations from the floor, as provided in the Constitution and By-Laws.

Dr. R. L. Rutledge, Alliance, placed in nomination the name of **Dr. E. O. Swartz, Cincinnati,** incumbent member of The Council from the First District. The nomination was seconded by Dr. Paul A. Davis, Akron.

There being no further nominations, on **motion** duly made, seconded and unanimously **carried**, the nominations were ordered closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for **Dr. Swartz,** as President-Elect.

At this point Dr. Swartz was escorted to the rostrum and he made a brief address of acceptance.

ELECTION OF COUNCILORS

The President then called upon the Nominating Committee for a report. The report was presented by Dr. D. W. Heusinkveld, Cincinnati, Chairman.

SECOND DISTRICT

As Councilor for the Second District, the committee placed in nomination the name of **Dr. Merrill D. Prugh, Dayton,** for a term of two years to succeed Dr. H. C. Messenger, Xenia, retiring automatically from The Council due to the fact that he had served three consecutive terms. The nomination of Dr. Prugh by the committee was seconded by Dr. J. E. Gillette, Versailles.

Dr. Russell L. Wiessinger, Sidney, placed in nomination the name of **Dr. George A. Woodhouse, Pleasant Hill.** The nomination of Dr. Woodhouse was seconded by Dr. Wm. M. Skipp, Youngstown.

There being no further nominations, on **motion** duly made, seconded and unanimously **carried**, the nominations were closed and the President instructed the Committee on Tellers and Judges of Election to distribute ballots so the House of Delegates could vote on the two nominations.

The House then voted and the following result was announced by the committee and the chair: Dr. Prugh, 69; Dr. Woodhouse, 44. Presi-

dent Brindley announced that **Dr. Prugh** had been elected Councilor of the Second District.

At this point Dr. Woodhouse moved that the vote in favor of Dr. Prugh be made unanimous. The **motion** was seconded and **carried.**

FOURTH DISTRICT

As Councilor for the Fourth District, the committee nominated **Dr. Carll S. Mundy, Toledo,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Mundy. This was done and Dr. Mundy was declared officially elected to The Council for the years 1949 and 1950.

SIXTH DISTRICT

As Councilor for the Sixth District, the committee nominated **Dr. Paul A. Davis, Akron,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Davis. This was done and Dr. Davis was declared officially elected to The Council for the years 1949 and 1950.

EIGHTH DISTRICT

As Councilor for the Eighth District, the committee nominated **Dr. Chester P. Swett, Lancaster,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Swett. This was done and Dr. Swett was declared officially elected to The Council for the years 1949 and 1950.

TENTH DISTRICT

As Councilor for the Tenth District, the committee nominated **Dr. H. M. Clodfelter, Columbus,** to succeed himself for a term of two years. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Clodfelter. This was done and Dr. Clodfelter was declared officially elected to The Council for the years 1949 and 1950.

ELECTION OF TREASURER

The Nominating Committee placed in nomination the name of **Dr. H. P. Worstell, Columbus,** to succeed himself as treasurer for a term of three years. There being no nominations from the floor, Dr. Worstell was re-elected treasurer.

A. M. A. DELEGATES ELECTED

The committee then presented nominations for the offices of delegate and alternate to the American Medical Association to be filled at this year's meeting, such delegates and alternates to take office January 1, 1950, and to serve for a term of two years, namely, 1950 and 1951.

The names of **Dr. L. Howard Schriver, Cincinnati,** and **Dr. E. O. Swartz, Cincinnati,** as delegate and alternate, respectively, to serve for a term of two years, starting January 1, 1950, were placed in nomination. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Schriver and Dr. Swartz. This was done and they were declared duly elected delegate and alternate to the American Medical Association for two years, starting January 1, 1950.

The names of **Dr. C. C. Sherburne, Columbus,** and **Dr. Richard L. Meiling, Columbus,** as delegate and alternate, respectively, to serve for a term of two years, starting January 1, 1950, were placed in nomination. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Sherburne and Dr. Meiling. This was done and they were declared duly elected delegate and alternate to the American Medical Association for two years, starting January 1, 1950.

The names of **Dr. Frank M. Wisely, Findlay,** and **Dr. Fred P. Berlin, Lima,** as delegate and alternate, respectively, to serve for a term of two years, starting January 1, 1950, were placed in nomination. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Wiseley and Dr. Berlin. This was done and they were declared duly elected delegate and alternate to the American Medical Association for two years, starting January 1, 1950.

The committee then placed in nomination the names of **Dr. A. A. Brindley, Toledo,** and **Dr. R. L. Rutledge, Alliance,** for delegate, and the name of **Dr. H. W. Lehrer, Sandusky,** as alternate for a two-year term, starting January 1, 1950.

There being no further nominations, Dr. Lincke, President-Elect, who had taken the chair at the request of President Brindley, ordered ballots distributed so the House of Delegates could vote for Dr. Brindley and Dr. Rutledge as dele-

gate. The House voted and the committee and the chair announced the following result: Dr. Brindley, 84 votes; Dr. Rutledge, 25 votes. Dr. Lincke then announced that **Dr. Brindley** had been elected delegate to the American Medical Association for a two-year term, starting January 1, 1950. Dr. Rutledge then moved that the vote for Dr. Brindley be made unanimous. The motion was seconded and adopted by the House of Delegates.

There being no further nominations for the office of alternate, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Lehrer as Dr. Brindley's alternate.

NEW FIRST DISTRICT COUNCILOR ELECTED

President Brindley then announced that due to the election of Dr. Swartz as President-Elect it would be necessary for the House of Delegates to nominate and elect a Councilor for the First District to serve the unexpired term of Dr. Swartz as a member of The Council.

Dr. Harry L. Fry, Cincinnati, placed in nomination the name of **Dr. D. W. Heusinkveld, Cincinnati,** to succeed Dr. Swartz on The Council for a period of one year. There being no further nominations, on **motion** duly made, seconded and unanimously **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Heusinkveld to succeed Dr. Swartz on The Council for one year—1949. This was done and **Dr. Heusinkveld** was declared elected to The Council for the year 1949.

OFFICERS INSTALLED

Dr. Brindley then installed the new officers and presented the official gavel of the Association to Dr. Lincke, who made a brief address of acceptance.

President Lincke then submitted the following appointments to the standing committees of the Association, which were confirmed by the House of Delegates on **motion** duly made, seconded and unanimously **carried.**

COMMITTEES CONFIRMED

Committee on Public Relations and Economics—Dr. Frederick P. Osgood, Toledo, for a term of five years. Dr. James G. Kramer, Akron, a member of the committee, to serve as chairman for the ensuing year.

Committee on Education—Dr. Thomas E. Rardin, Columbus, for a term of five years. Dr. Carl A. Wilzbach, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. John A. Caldwell, Cincinnati, for a term of five years, and to serve as chairman for the ensuing year.

Committee on Scientific Work—Dr. A. Carlton Ernstene, Cleveland, for a term of five years. Dr. Martin W. Diethelm, Toledo, a member of the committee, to serve as chairman for the ensuing year.

On **motion** duly made, seconded and unanimously **carried,** the foregoing appointments by President Lincke were confirmed by the House of Delegates.

VOTE OF APPRECIATION

Under the order of new business Dr. Roy E. Shell, Van Wert, presented a motion expressing thanks and appreciation to all who had played a part in making the 1949 Annual Meeting a success, including the managements of the Neil House and Deshler-Wallick Hotel, Columbus newspapers and radio stations, the Committee on Scientific Work, the Committee on Scientific Exhibits, the officers and committees of the various sections and the members of the Columbus office staff. The motion was seconded by many and adopted unanimously.

Dr. J. E. Gillette, Versailles, then moved that a rising vote of thanks to Dr. Brindley for his splendid work as President during the past year be adopted. This motion was seconded by many and the motion was adopted by a rising vote.

The chair announced that word had been received of the untimely death of Dr. J. R. Tillotson, Lima, a former long-time member of the House of Delegates and who had been in attendance at this meeting on Wednesday. On **motion** duly made, seconded and unanimously **carried,** the House, by a rising vote, expressed sincere sympathy and instructed the Executive Secretary to send a message of condolence to Mrs. Tillotson and other members of Dr. Tillotson's family.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary.

Doctors for Canal Zone

Permanent appointments for physicians in the Civil Service now exist in the Panama Canal Medical Service according to an announcement from the Office of The Panama Canal, Washington, D. C.

Early applications are suggested, by the Panama Canal Office, from physicians who desire the opportunity for training and experience in tropical medicine under standard American living conditions. Starting professional salaries are $5,599 and $6,540 a year, with free transportation to the Canal Zone provided for physicians, their families and household goods.

HOUSE OF DELEGATES
ROLL CALL—1949 MEETING

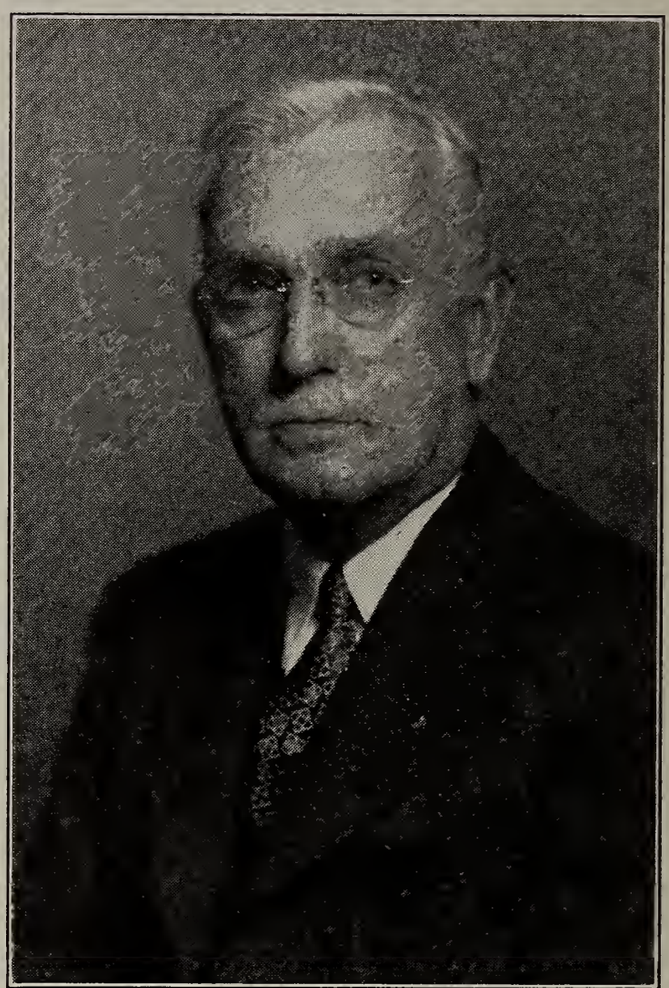
County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	S. J. Ellison	Present	Present
BROWN			
BUTLER	C. T. Atkinson	Present	Present
	H. M. Lowell	Present	Present
CLERMONT	G. E. Rockwell	Present	Present
CLINTON	Edmond K. Yantes	Present	Present
HAMILTON	William A. Altemeier	Present	----------
	Harry L. Fry	Present	Present
	Richard B. Homan	Present	Present
	Daniel V. Jones	Present	Present
	Arthur W. Wendel	Present	----------
	Robert H. Kotte	Present	Present
	Joseph Lindner	Present	Present
	Richard D. Bryant	Present	----------
	D. W. Heusinkveld	Present	Present
HIGHLAND	J. Martin Byers	Present	Present
WARREN	O. L. Layman	Present	Present
	SECOND DISTRICT		
CHAMPAIGN	D. C. Houser	Present	Present
CLARK	Ray M. Turner	Present	Present
	H. H. Ingling	Present	Present
DARKE	J. E. Gillette	Present	Present
GREENE	C. G. McPherson	Present	Present
MIAMI	G. A. Woodhouse	Present	Present
MONTGOMERY	M. D. Prugh	Present	Present
	R. D. Dooley	Present	Present
	R. S. Binkley	Present	Present
	A. W. Carley	Present	Present
PREBLE	C. E. Newbold	----------	----------
SHELBY	Russell L. Wiessinger	Present	Present
	THIRD DISTRICT		
ALLEN	F. P. Berlin	Present	Present
AUGLAIZE	R. G. Hunter	----------	Present
	Elizabeth Y. Kuffner	Present	----------
CRAWFORD	John S. Kiess	----------	----------
HANCOCK	Frank M. Wiseley	Present	Present
HARDIN	Floyd M. Elliott	Present	Present
LOGAN	Hobart L. Mikesell	Present	Present
MARION	A. E. Morrison	Present	----------
MERCER	E. J. McLaughlin	Present	Present
SENECA	Paul J. Leahy	----------	Present
VAN WERT	Roy E. Shell	Present	Present
WYANDOT	C. B. Schoolfield	Present	Present
	FOURTH DISTRICT		
DEFIANCE	D. J. Slosser	Present	Present
FULTON	R. E. Merrill	----------	Present
HENRY	B. L. Johnson	----------	Present
LUCAS	A. L. Bershon	Present	Present
	O. E. Todd	Present	Present
	E. E. Lyon	Present	Present
	R. Kuebbeler	Present	Present
	R. A. Diethelm	Present	Present
OTTAWA	G. A. Boon	Present	Present
PAULDING	Ray Mouser	----------	----------
PUTNAM	W. B. Recker	Present	Present
SANDUSKY	H. L. Keiser	Present	Present
WILLIAMS	H. W. Wertz	Present	Present
WOOD	Paul F. Orr	Present	Present
	FIFTH DISTRICT		
ASHTABULA	P. J. Collander	----------	----------
CUYAHOGA	D. A. Chambers	Present	Present
	J. H. Budd	Present	Present
	D. C. Darrah	Present	Present
	C. L. Hudson	Present	Present
	J. H. Lazzari	Present	Present
	J. T. Ledman	Present	Present
	F. A. LeFevre	Present	Present
	J. D. Osmond, Jr.	Present	Present
	George Tischler	Present	Present
	R. R. Renner	Present	Present
	Robert M. Hosler	----------	Present
	R. J. Whitacre	Present	----------
	W. E. Smith	----------	Present
	J. W. Conwell	Present	Present
	I. L. Schonberg	----------	Present
	H. B. Wright	Present	Present
	M. P. Motto	Present	----------
GEAUGA	Phillip P. Pease	----------	----------
LAKE	B. S. Park	Present	Present
	SIXTH DISTRICT		
COLUMBIANA	P. H. Beaver	Present	Present
MAHONING	E. J. Wenaas	Present	Present
	R. E. Odom	----------	Present
	I. C. Smith	Present	----------
	Wm. M. Skipp	Present	Present
PORTAGE	R. C. Neely	Present	----------
STARK	L. E. Anderson	Present	Present
	R. K. Ramsayer	Present	Present
	C. C. Couch	Present	Present
SUMMIT	R. E. Pinkerton	Present	Present
	Kurt Weidenthal	Present	Present
	L. E. Witzeman	Present	Present
	E. W. Burgner	Present	Present
TRUMBULL	S. J. Shapiro	Present	----------
	E. G. Kyle	----------	Present
	SEVENTH DISTRICT		
BELMONT	D. Myers Creamer	Present	----------
CARROLL	S. L. Weir	Present	----------
	Glenn C. Dowell	----------	Present
COSHOCTON	E. J. Booth	----------	----------
HARRISON	Carl F. Goll	Present	Present
JEFFERSON	Max H. Rosenblum	----------	Present
MONROE	A. R. Burkhart	----------	----------
TUSCARAWAS	J. S. Adler	Present	Present
	EIGHTH DISTRICT		
ATHENS	P. J. Woolworth	Present	----------
FAIRFIELD	L. E. Stenger	Present	Present
GUERNSEY	Robert A. Ringer	Present	Present
LICKING	George A. Gressle	Present	Present
MORGAN	A. A. Coulson	----------	----------
MUSKINGUM	George C. Malley	Present	Present
NOBLE	Edward G. Ditch	Present	----------
PERRY	James Miller	----------	----------
WASHINGTON	Kenneth E. Bennett	----------	Present
	NINTH DISTRICT		
GALLIA	Charles E. Holzer, Jr.	----------	----------
HOCKING	C. T. Grattidge	Present	----------
JACKSON	Earl J. Levine	Present	Present
LAWRENCE	Wm. Ray Swango	Present	Present
MEIGS	R. E. Boice	Present	----------
PIKE	Paul H. Jones	----------	Present
SCIOTO	W. A. Quinn	----------	Present
VINTON	H. D. Chamberlain	Present	Present
	TENTH DISTRICT		
DELAWARE	E. V. Arnold	Present	Present
FAYETTE	J. H. Persinger	Present	Present
FRANKLIN	Grant O. Graves	Present	Present
	Warren G. Harding, 2nd	Present	Present
	Charles W. Pavey	Present	Present
	F. C. Hugenberger	Present	Present
	Phillip T. Knies	Present	Present
	Richard L. Meiling	Present	Present
	H. R. Mitchell	Present	Present
KNOX	H. T. Lapp	Present	Present
MADISON	E. S. Crouch	----------	Present
MORROW	J. P. Ingmire	Present	----------
PICKAWAY	E. S. Shane	Present	----------
ROSS	Ralph W. Holmes	Present	Present
UNION	E. J. Marsh	Present	Present
	ELEVENTH DISTRICT		
ASHLAND	G. D. Fridline	Present	Present
ERIE	Ross M. Knoble	Present	Present
HOLMES	N. P. Stauffer	Present	Present
HURON	O. J. Nicholson	Present	Present
LORAIN	George A. Hoke	Present	Present
	Theodore Berg	Present	Present
MEDINA	R. F. Fasoli	----------	----------
RICHLAND	P. A. Blackstone	Present	Present
WAYNE	Lyman A. Adair	Present	----------
	OFFICERS		
President	A. A. Brindley	Present	Present
President-Elect	Carl A. Lincke	Present	Present
Past-President	R. L. Rutledge	Present	Present
Treasurer	H. P. Worstell	Present	Present
	COUNCILORS		
District			
First	E. O. Swartz	Present	Present
Second	H. C. Messenger	Present	Present
Third	J. Craig Bowman	Present	Present
Fourth	Carll S. Mundy	Present	Present
Fifth	Fred W. Dixon	----------	Present
Sixth	Paul A. Davis	Present	Present
Seventh	R. J. Foster	Present	Present
Eighth	Chester P. Swett	Present	Present
Ninth	J. P. McAfee	Present	Present
Tenth	H. M. Clodfelter	Present	Present
Eleventh	John S. Hattery	Present	Present
	Totals	126	123

Presenting . . .

The New President-Elect and Other New Officers of the Association Named by the House of Delegates at Annual Meeting, April 19-22

FOLLOWING are biographical sketches of the new President-Elect and new members of The Council, elected by the House of Delegates of the Ohio State Medical Association at the 1949 Annual Meeting, held in Columbus, April 19-22, also a biographical sketch of the incoming President who was installed in office at the meeting.

Dr. Ernest O. Swartz, named President-Elect of the Ohio State Medical Association, comes into the office with a rich background of medical organization activities. As President-Elect he will continue to serve on The Council and will assume office as President at the Annual Meeting in Cleveland next May.



E. O. SWARTZ, M. D.

Dr. Swartz was born in Loudonville in Ashland County on February 6, 1880. He attended school at Portsmouth and completed his preparatory education at Kings Mills High School in Warren County. For his premedical training he attended Doane Academy and Denison University, Granville, where he received his first college degree. In 1905 he received his degree as a Doctor of Medicine after completing the course at the Medical College of Ohio—now the University of Cincinnati College of Medicine.

He was licensed the same year in this State after examination by the Ohio State Board of Medical Registration, and in 1907 was licensed also by the Wisconsin State Board. After serving as intern and later as resident in medicine in the Cincinnati General Hospital, he engaged in general practice in Cincinnati and continued this practice until 1917.

In that year he began a year of graduate study in urology at Johns Hopkins Medical College and was assistant in urology at The Brady Urological Clinic, Johns Hopkins Hospital from 1918 to 1921. During this time, under a grant from the U. S. Department of the Interior Hygiene Board, he collaborated in the production and its presentation to the medical profession of Mercurochrome.

From 1921 to the present time, Dr. Swartz has continued his practice in Cincinnati, limiting his work to genito-urinary surgery. He has contributed many articles to the urological literature.

Dr. Swartz served as president of the Cincinnati Academy of Medicine for the term 1939-40. He served on The Council as Councilor for the First District from 1943 to 1949, and is serving as an alternate delegate to the American Medical Association. He served on a number of committees of the Association and subcommittees of The Council,

among which were the Committee on Public Relations and Economics, the Committee on Industrial Health, the Committee on Poor Relief, and the Auditing and Appropriations Committee of which he was chairman.

Dr. Swartz also has been active in medical and health work outside of the Association. He was a member of the Coordinating Committee of the Cincinnati Public Health Federation. He is a member of the American Urological Association, a Fellow of the American College of Surgeons and a Diplomate of the American Board of Urology.

At present Dr. Swartz is assistant professor of surgery, Department of Urology, University of Cincinnati College of Medicine. Also he is attending urologist at Cincinnati General Hospital, the Children's Hospital, Christ Hospital and Deaconess Hospital, and is past-director and senior attending urologist at Jewish Hospital and Bethesda Hospital.

His civic and fraternal activities include memberships in Linwood Lodge, F. & A. M., Cincinnati Consistory Scottish Rite Bodies, Syrian Temple Mystic Shrine, Nu Sigma Nu Medical Fraternity, the Cincinnati Club, University Club, Travel Club, Pelee Club and the Cincinnati Automobile Club. By church preference he is a Baptist.

His hobbies include fishing, hunting and gardening. Dr. and Mrs. Swartz have one son, Dr. William T. Swartz, who is on the staff of the Veterans Administration Hospital in Dayton.

INCOMING PRESIDENT

Dr. Carl A. Lincke who assumed office as President for the coming year, was elected at the Annual Meeting last year in Cincinnati.

Though born and educated in the city, Dr. Lincke chose to practice his profession in one of the most sparsely populated counties in Ohio, and has become known among his colleagues as a representative "country doctor."

Dr. Lincke was born on Christmas Day, 1905, in Alliance, where he received his elementary and secondary education. He then went to Ohio State University where he received his premedical training and in 1931 received his degree from the College of Medicine. After a year's internship at White Cross Hospital in Columbus he began his practice in Carrollton.

Prior to being designated as President-Elect last year, Dr. Lincke served six years on The Council as Councilor for the Seventh District. He is a past-president of the Carroll County Medical Society and served for six years as secretary of that organization.

He is one of the founders of Ohio Medical Indemnity, Inc. (the Ohio Doctors' Plan), and is a member of the Board of Directors and executive committee of the plan. He is one of Ohio's delegates to the American Medical Association. Dr. Lincke has served as chairman of the Auditing and Appropriations Committee, as a member of the Committee on Extension of Activities, and as President-Elect served in an ex-officio capacity on several other committees.



C. A. LINCKE, M. D.

Dr. Lincke also is active in affairs of his community. He is vice-president of the Cummings Bank at Carrollton, is a member of the Carrollton Rotary Club, the Masonic Lodge, the Elks Lodge and Nu Sigma Nu Medical Fraternity.

Dr. and Mrs. Lincke have two children, a son and a daughter. His hobbies include hunting, fishing and traveling.

FIRST DISTRICT COUNCILOR

Dr. David W. Heusinkveld of Cincinnati was elected by the House of Delegates to serve out the unexpired term of Dr. Swartz as Councilor for the First District. The term expires with the 1950 Annual Meeting of the Association.

Dr. Heusinkveld was born in Fulton, Ill., on July 17, 1897, and completed his preparatory education at Clinton High School, Clinton, Iowa. From 1916 to 1918 he attended Hope College at Holland, Mich.



D. W. HEUSINKVELD, M. D.

He served as an infantry officer during World War I, after which he attended the University of Chicago where he received his B. S. degree in 1921. He continued his studies at Rush Medical College, University of Chicago, and received his degree as a Doctor of Medicine in 1925.

After an internship at the Cincinnati General Hospital, Dr. Heusinkveld began practice in that city. He is specializing in diseases of the chest.

Dr. Heusinkveld is instructor in medicine at the University of Cincinnati College of Medicine and is on the attending staffs at Dunham

Hospital, Good Samaritan Hospital and Bethesda Hospital.

He is president of the Cincinnati College of Medicine, is governor for Ohio of the American College of Chest Physicians and is a member of the Trudeau Society.

Dr. and Mrs. Heusinkveld have two sons—David W. who is a sophomore at Dartmouth Medical School and Dennon D., a freshman at Dartmouth College.

SECOND DISTRICT COUNCILOR

Dr. Merrill D. Prugh of Dayton, elected Councilor for the Second District, succeeds Dr. H. C. Messenger of Xenia in that office.



M. D. PRUGH, M. D.

Born in Preble County, February 21, 1884, Dr. Prugh received his primary and secondary education in the public schools and graduated from Miami University, Oxford, with an A. B. degree.

He then attended Hahnemann Medical College of Philadelphia where he received his degree as Doctor of Medicine in 1909, after which he took his internship at Genessee Valley Hospital, Rochester, N. Y.

Dr. Prugh then went to the British Isles where he took graduate work in general surgery at the University of Edinburg and London Postgraduate Medical College.

During World War I, he served eight months at a base hospital with the American Expeditionary Forces where he held the rank of captain. He later acquired the rank of major in the Medical Reserve Corps.

Dr. Prugh has been active in medical organization work in the Dayton area, where he is a past-president of the Montgomery County Medical Society. He also is a Fellow of the American Medical Association and of the American College of Surgeons. He served five years on the War Participation Committee of the Ohio State Medical Association.

Dr. Prugh limits his practice to general surgery in association with his son, Dr. Reed C. Prugh. He is on the senior surgical staff of the Good Samaritan Hospital and on the courtesy surgical staffs of Miami Valley Hospital and St. Elizabeth Hospital.

PAST-PRESIDENT

Dr. A. A. Brindley, Toledo, as immediate Past-President will continue to serve on The Council, succeeding Dr. R. L. Rutledge of Alliance in that office.

COUNCILORS AND TREASURER REELECTED

Dr. H. P. Worstell of Columbus was reelected for an additional three-year term as treasurer. He was elected to that office at the 1946 Annual Meeting.

Councilors elected for additional two-year terms are the following: Fourth District—Dr. Carll S. Mundy, Toledo; Sixth District—Dr. Paul A. Davis, Akron; Eighth District—Dr. Chester P. Swett, Lancaster; Tenth District—Dr. H. M. Clodfelter, Columbus.

Other Councilors, in the midst of their two-year terms, are: Third District—Dr. J. Craig Bowman, Upper Sandusky; Fifth District—Dr. Fred W. Dixon, Cleveland; Seventh District—Dr. R. J. Foster, New Philadelphia; Ninth District—Dr. J. P. McAfee, Portsmouth; Eleventh District—Dr. John S. Hattery, Mansfield.

Doctors' Orchestra To Conclude 23rd Season

On June 2 the Doctors' Orchestra of Akron will end its 23rd season with its 134th concert.

Founded in 1926, the Orchestra has given concerts in 11 cities and towns of Ohio for 25 hospitals and similar institutions and medical, dental or nursing organizations, including three state organizations—the Ohio State Medical Association, Ohio State Eclectic Medical Association, Ohio State Nurses Association.

It has carried on without interruption even during the Second World War when 32 per cent of the members joined the armed forces. Two were killed, one died and two were badly injured. But the members at home kept up the musical work, though with reduced numbers. The season just ended has been the best in the 23 years of the Orchestra's history, both musically and in attendance and enthusiasm, the director reported, adding that musically the Orchestra is excellent and of professional calibre.

The 24th season will open when rehearsals are resumed in October. Already concerts have been arranged for the Children's Home, Summer Home for the Aged, Our Lady of the Elms Convent and for four hospitals—the Children's, St. Thomas, City Hospital of Akron and a benefit concert for the Citizens Hospital of Barberton. Dr. A. S. McCormick is conductor and Dr. A. Dobkin is concertmaster. They with Dr. R. E. Pinkerton form the Executive Committee. The personnel number 41.

Announcement was made that a 70-bed convalescent hospital will be built on an 80-acre site between Troy and Piqua with $1,200,000 left for that purpose by the late Jacob G. Dettmer.

'Time Marches On' . . .

President of Association Reviews Year of Activity and Emphasizes Mounting Responsibilities of Profession in Annual Meeting Address

By A. A. Brindley, M. D.

(Presented to House of Delegates, April 19, 1949, Columbus, Ohio)

ONE year ago this House of Delegates sat serenely and complacently, thinking that the day of the New Deal was about over. Confidently, we said to ourselves, "Now, we will have time to counteract false propaganda with factual information; to let the public know that the sole objective of the medical profession is to work continuously to improve medical and health services; to show that radical programs are unnecessary."

We were so sure that another crisis had passed that we failed to realize the depth to which the bug of state socialism had bored. Like many other groups and individuals, we went to sleep at the switch. Then in rapid succession our serenity and complacency were punctured by a series of disturbing events.

First came Mr. Ewing's National Health Assembly; then Mr. Ewing's report on the nation's health; then the general election; then Mr. Truman's national health plan; lastly, proposed legislation in the Congress which would make all of us servants of the state.

REAL AWAKENING NEEDED

I remind you of these events and developments in order to emphasize our need today, more than ever before, for a real awakening within our ranks; for a strong, aggressive organization which will command the support and loyalty of all of the members and be worthy of the confidence and respect of the people of Ohio.

In my opinion we have that kind of an organization in the Ohio State Medical Association. The aim of each and everyone of us should be to keep it such by giving it our active and undivided support.

It is unnecessary for me to discuss here the accomplishments of the Ohio State Medical Association during or prior to my services as your presiding officer. No state medical society in the country presents to its membership in more detail or with more dispatch, reports on its activities. *The Ohio State Medical Journal*, the best in the country, the *OSMAgram*, bulletins and personal communications, keep our members well informed on current events and developments and on the programs of the Association. Perhaps I should say, they keep well informed those members who take the time to read them.

A MEMBER'S RESPONSIBILITY

This is your Association. Your money finances its operations. You, the members of this House of Delegates, are officers of this Association, sent here by your county medical societies to formulate policies and to transact other business of the Association. The Association operates under the policies which you formulate. If those policies are right, you may expect the right kind of results from your elective and administrative officials. If the results are not to your liking, then it is your right and responsibility to change both the policies and the officials.

I do desire, however, to make special mention of two specific activities of your Association.

RURAL HEALTH PROGRAM

First: Four years ago I was privileged to recommend to Dr. Schriver, then the President of the Association, a colleague and friend as chairman of the newly formed Committee on Rural Health. Had I never done anything else for organized medicine I would consider my debt paid in full. Dr. Carll S. Mundy, Toledo, the physician I refer to, has guided the destinies of the Committee on Rural Health from a place where it was a straggling onlooker to one of virile and dynamic leadership in the rural health activities of Ohio and the nation. His committee is mature, experienced, and progressive. It has established an outstanding record and in cooperation with other groups has done much to promote better health among the rural communities of our state. Its work has been of tremendous value in advancing the cause of preventive medicine and in improving the public relations of the medical profession of Ohio. This is a fine example of how each of the points of our Twenty-Five Point Health Program for Ohio can be translated into life and action. The work of that committee deserves

the support and praise of every one of our members.

THE EXECUTIVE OFFICE

Second: I wish to comment about our Executive Office at Columbus and its Department of Public Relations.

It has been my privilege to meet and to know most of the executive secretaries of the state medical societies of this country. This privilege has made me realize how extremely fortunate we are, and how deeply grateful we should feel, here in Ohio. Chuck Nelson stands today as an outstanding authority on the administrative phases of medical organization. He is recognized by his conferees as tops. He has ideals as well as ideas; balance and poise; and the other attributes which have won for him the respect and confidence of our members and of those outside the medical profession. His devotion to the ideals of the profession, his genius for organizing our activities and his constructive efforts in our behalf have been an inspiration to those of us who have learned to know him and love him during his twenty-one years of service with the Association.

PUBLIC RELATIONS WORK

Our Department of Public Relations, organized about ten years ago when our great beloved friend and colleague, the late Dr. Barney Hein was president, has for the past three years been under the direction of Scottie Saville, assisted by Hart Page. Under their guidance, it has grown, achieved much, and is now recognized as one of our greatest assets.

Perhaps all of you can remember the excellent pamphlet which it produced, "The 25 To Keep Alive," in which our health program for Ohio was summarized. Thousands of copies were distributed and it was used by many other state and local medical societies as a sample for similar pamphlets in all parts of the country. Copies went to schools, universities, clubs, students, and many others, telling them about the things for which the medical profession stands and recommending activities which can be carried on in any community to improve the health of all citizens.

Then came the pamphlet, "Your Guide To the Services of the Ohio State Medical Association." This remarkable brochure provided just the information needed by our members, especially the younger ones. It deserved a better fate than being consigned to the lower drawer—a fate which I fear resulted in some instances.

Following came the excellent pamphlet on Brucellosis, engineered by Assistant Director Page, which has been distributed to thousands of farmers in Ohio. This bit of public relations and health education did more for the medical profession, as well as for the folks who read it, at the right time than most of us can imagine.

Within the past year, "Date With the Doctor" appeared. Requests for this timely and helpful booklet have come from all over the country, attesting to its value.

These are just a few examples of some of the tangible things which the department has done. Time will not permit even a summary of the many other activities which it has carried on, all of which have played a vital part in our public education program.

PART OF INDIVIDUAL PHYSICIAN

Recently the Department of Public Relations sent a memorandum to The Council. In this it was emphasized that Medicine has three basic channels for molding public opinion in Ohio.

1. The Ohio State Medical Association.
2. The County Medical Society.
3. The Individual Physician.

Much could be said about all of these, but I wish to discuss with you just for a moment the third channel—the individual physician.

Dr. Casper F. Hegner recently said: "Organized medicine is the guardian of the health of the people, the sponsor of progressive medical education and service, the improvement of hospitals, and advocate of unhampered private practice, the champion of every honorable, honest competent practitioner."

RAPS MERCENARY DOCTOR

If any man licensed to practice medicine in Ohio is interested only in the practice of medicine as a commercial venture, then he doesn't belong in the Ohio State Medical Association.

If we will but look at the situation objectively, we will find that our relationship with the public is not what it should be. We find that far too many people are dissatisfied and disgruntled over the attitude of some members of our profession.

We hear complaints about over-charging, refusal to make calls, arrogance, and even questionable practices, all of which have caused bad feeling between patients and their doctors and for which the medical profession as a whole has been blamed.

CAN'T TOLERATE UNETHICAL PRACTICE

We may say: These situations are exceptions to the rule. They are. Nevertheless, there are enough of them to create an unwholesome situation for the entire medical profession. True, unethical and unprofessional practices are not condoned by the profession generally, but still they are a reflection on the innocent as well as the guilty members of the profession. It is time for us to take inventory.

The one question asked of me most often during the past year by physicians throughout

the state has been: "Why doesn't the Ohio State Medical Association set up some mechanism similar to the so-called Colorado Plan for disciplinary action against its offending members?"

UP TO COUNTY SOCIETY TO ACT

I said to them, and I say to you as the representatives of the eighty-eight county medical societies of Ohio, that special machinery is not necessary. Each county medical society chartered by the Ohio State Medical Association and operating under a constitution and by-laws approved by the state society has, under its own constitution, the authority to regulate and to discipline its own members.

The responsibility is primarily local. The State Association has no jurisdiction over the ethical and professional conduct of its members unless the local medical society refuses to act in flagrant violations. The State Association should not have to step in and I don't believe we would want it to do so. All is needed is courageous action on the part of each county medical society.

ACTION IMPERATIVE

This situation which I have referred to in a general way is serious. It must be met and solved—not by someone else but by the medical profession itself. I recommend that each of you take back to your county medical society this admonition: The medical profession owes it to the public to take prompt and stern disciplinary action against those members who are bringing discredit to the entire profession and playing fast and loose with the public.

I firmly believe that it is imperative and mandatory for us to act on these matters and act quickly. If we do, we will rapidly regain the good will and esteem of most of the public; we will bring about improvement in the services rendered to the public; we will eliminate the basis for some of the charges which are being hurled at the medical profession by those who are demanding that the government take over our entire system of medical practice.

LAUDS DRUGGISTS

At this point I wish to compliment the Ohio State Pharmaceutical Association which is making a firm and constructive effort to wipe out the practice of giving rebates on prescriptions and appliances. Also, the Cleveland Academy of Medicine deserves special commendation for its action in working with the Better Business Bureau in an attempt to prevent rebates and other unethical practices.

I repeat, these are local problems and the solution rests with the local medical societies. Immediate action against offenders is imperative.

My criticism of individual doctors is presented only as a constructive effort to correct what I believe is a glaring defect and to stimulate action on a matter which is causing the profession great harm.

MUST WIN PUBLIC SUPPORT

My love for medicine is intense and likewise my love for my fellow practitioners. I am sincere in the belief that only through the concerted efforts of the individual physician can this fight against the move to socialize our profession be won. Medicine is only the whipping boy in the drive for state socialism generally. Medicine cannot fight alone. We need not fight alone if we will but clean up our own ranks and give the people the facts. To every patient we see we should discuss the value and necessity for voluntary medical and hospital insurance; how it gives the American people the best product at the best price. We should tell our patients that American Medicine is the best in the world—and why; because it has fostered individual initiative and has provided an incentive to each doctor to do better work.

Tell your patients that the cost of cigarettes for an average smoker or one movie a week for the average family will buy the best kind of health protection—voluntary health protection. Show them by practicing the kind of medicine the Ohio State Medical Association has fostered and supported for 103 years, that the doctors of Ohio are not only fighting against disease; not only fighting to save human lives but are fighting to save America. Then let them decide whether they want "Men of Medicine" or "medicine men" in charge of the health of their families.

WOMAN'S AUXILIARY

My immediate predecessor, Dr. Rutledge, has a favorite expression: "Never underestimate the power of women." This is particularly applicable to the Woman's Auxiliary of the Ohio State Medical Association. The remarkable progress made by the Woman's Auxiliary under the able guidance of my good friend and neighbor, Mrs. Jean Gillette, is music to our ears. The Auxiliary has had excellent supervision by the Advisory Committee of The Council. It has done its job well. The fact that as of April 15 the Auxiliary had a paid-up membership of approximately 3,100 indicates the keen interest of the doctor's wife in her husband's profession and the programs of that profession.

State-wide, the aid and assistance of the Auxiliary to the nursing profession by helping in the recruitment of student nurses have been of utmost value and came at a time when such aid was greatly needed. Likewise, the public relations and health education activities of the Auxiliary have been outstanding. Special mention should be made of the work at the county

THE COUNCIL AND HOUSE OF DELEGATES INITIATE FOLLOW-UP ON A. M. A. ASSESSMENT

Pursuant to action by The Council confirmed by the House of Delegates, endorsing the A. M. A. Education Campaign and the A. M. A. $25.00 assessment, President Carl A. Lincke is sending a letter to all members of the Ohio State Medical Association who have not paid the A. M. A. assessment, urging them to do so.

Also, the names of members who have not paid the assessment are being sent to the President and the Secretary of each County Medical Society, with a request that the County Society urge these members to pay the assessment.

Approximately 50 per cent of the membership has paid the assessment as a result of one general letter to the membership.

fairs and at health institutes held in some communities. The Woman's Auxiliary, with its active local units, cannot help but provide an active stimulus and be a real asset in our public relations campaign during the coming year.

THE FUTURE

Your Ohio State Medical Association has reached maturity. It is a leader in the field. Its counsel and guidance are sought by other state medical societies and by scores and scores of organizations and groups outside the medical profession. It has worked with others and will continue to do so. It has tried to give its members the kind of services they need and demand.

I am happy and honored to have been of some service in this great organization. I can never appropriately express my gratitude to you who have made this service possible.

Time marches on—but not alone. We too must go on. Let us so live each day that we may be better doctors, better citizens, better men and women.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since April 7, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ALLEN COUNTY
Wm. F. Kaumeyer, Lima

CUYAHOGA COUNTY
Donald E. Eiber, Cleveland
Jack R. Henry, Cleveland
Daniel R. Keating, Cleveland
Lewis Lehrer, Cleveland
Jane P. McCollough, Cleveland

HAMILTON COUNTY
Emil L. Barrows, Cincinnati

HURON COUNTY
Frederick C. Henry, Monroeville

STARK COUNTY
Herbert A. Jones, Canton
A. H. Karam, Canton
Adolf Krakauer, Massillon

TRUMBULL COUNTY
Ralph E. Meacham, Warren
Nevin Trimbur, Warren

Ohio Academy of General Practice Elects Officers

Dr. Ross M. Knoble, Sandusky, was named president-elect by the Ohio Academy of General Practice, during its second annual meeting held April 19 in Columbus concurrently with the Annual Meeting of the Ohio State Medical Association.

Dr. Noble is a delegate of the Erie County Medical Society to the O. S. M. A., is former Councilor from the Eleventh District and is retiring chairman of the O. S. M. A. Section on General Practice.

Dr. Emery G. Kyle, Newton Falls, assumed office as president of the organization, succeeding Dr. Joseph W. Lindner of Cincinnati. Dr. Earl D. McCallister, Columbus, is the new secretary-treasurer of the Academy.

Army Extends Professional Education Program

Beginning July 1, 1949, Valley Forge Army General Hospital, Phoenixville, Pennsylvania, will participate in the graduate professional education program, it was announced by Major General R. W. Bliss, surgeon general. This will bring the number of general Army hospitals participating in this program to nine, and will open a new source of training to young physicians interested in the Army Military Intern Program. The Army has extended an invitation to medical students to visit its training hospitals during the summer months. All participating hospitals are approved for such teaching by the Council on Medical Education and Hospitals of the American Medical Association.

Three hundred internships are available yearly. As of March 14, there were 113 military interns on duty in Army training hospitals, with 232 new men selected to begin July 1. Of the 113 officers on duty, 73 have been offered residencies in Army General hospitals, and one in a civilian hospital under the Civilian Intern Program.

Annual Meeting Review . . .

Extensive Educational Program, Scientific Exhibit, Banquet and Other Features Add Up To Make Most Successful Session on Record

IN two outstanding respects the 1949 Annual Meeting of the Ohio State Medical Association was one of the most successful meetings in its history—it encompassed more than 60 different group meetings with a combined lecture and panel faculty of approximately 250 physicians and lay experts; and it drew the largest number of persons ever to attend a similar gathering.

The number of persons who registered was 2,608, 194 more than at the previous record meeting in Cleveland two years ago. A breakdown of the registration is given on page 622 of this issue.

EDUCATIONAL FEATURES

The vast array of medical talent on the educational program, including 13 out-of-state physician lecturers, gave members an unusually large number of courses from which to choose.

Specialty Section meetings, held during the morning hours, drew groups estimated at from approximately 75 to, in some instances, well over a hundred persons. Specialty Section sessions were conducted by their respective officers and panels of experts.

The 18 instructional courses in all cases were well attended. This is the third year in which instructional courses have been features of the Annual Meeting. They again proved themselves vital features of the meetings. Moderators and their panels kept the discussions on a practical and informal level which proved popular with those who attended.

General Sessions, held in the Main Ballroom of the Neil House, drew large numbers who heard discussions by Ohio and out-of-state physicians. Sessions were held on two separate days and in each case consisted of three half-hour discussions.

"Information Please" was an informal session held Thursday evening in the Main Ballroom of the Neil House. Officials of the Industrial Commission, the Ohio Department of Health and the Ohio Department of Public Welfare took part and answered questions relating to their respective agencies.

"Medical Topics of the Day" was the title given to a group of discussions held Wednesday afternoon. These five groups gave members an opportunity to pick the subjects in which they were most interested.

Round-Table Discussions held on Friday morning brought to a close the 1949 meeting. Six of these groups on medical subjects were held. Although attendance was not as high as anticipated, informality in the limited groups more than compensated for numbers.

COUNCIL AND HOUSE OF DELEGATES

The Council met in regular session on Monday, April 18, on the eve of the Annual Meeting. Details of the extensive business transacted at this meeting are given on page 598 of this issue. A special meeting of The Council was called by the Incoming President immediately after adjournment of The House of Delegates. Minutes of this meeting are included in the Proceedings of The Council.

The House of Delegates held its first meeting on Tuesday evening, the first day of the Annual Meeting, and its second meeting Thursday noon and afternoon. Proceedings of these meetings, including election of officers, action on resolutions, and appointment of committeemen, are given on page 601 of this issue.

BANQUET

A welcomed pause in the four-day scientific program was the Annual Banquet held Wednesday evening, in the Main Ballroom of the Neil House. Because of limited facilities, all tickets were claimed in advance, and the hall was filled to capacity. In spite of the large gathering, however, hotel personnel did an excellent job in serving an appetizing meal.

The banquet was purely a social affair with entertainment in the form of a floor show and vaudeville acts.

Dr. R. L. Rutledge, Past-President, presented Dr. A. A. Brindley, retiring President, with a replica of the official gavel used during his year in office.

Following the elaborate dinner and special entertainment, members and their wives and guests enjoyed an evening of dancing. Willie Fischer and his orchestra gave dancers some refreshing variations from the conventional type of music.

PUBLIC RELATIONS

The Annual Meeting was well publicized by press and radio. Press releases prepared in advance and on the spot by the Association's Public Relations Department were furnished to the wire services and to local newspapers and radio stations.

In addition to local reporters, the meeting

Camera Records Some Activities at Annual Meeting



1. Members of group from Muskingum County Medical Society chat between dances following banquet.
2. Dr. E. O. Swartz accepts House of Delegates designation of him as President-Elect of the Association.
3. Dr. Max M. Zinninger (center) reminisces with a group of former students from the University of Cincinnati College of Medicine.
4. Incoming-President Lincke, President-Elect Swartz and Retiring President Brindley get together.
5. Dr. W. H. McGaw (right) explains display on "Pneumo-Arthrography of the Knee," which won second prize among the scientific exhibits. The exhibit was sponsored by Dr. McGaw, Dr. M. D. Sachs and Dr. J. M. Muckley, all of Cleveland.
6. Dr. Henry A. Zimmerman (facing camera) explains exhibit on "Application of Intracardiac Catheterization in the Diagnosis of Congenital Heart Disease." The first place winner in the scientific exhibits was sponsored by Dr. Roy W. Scott and Dr. Zimmerman of Cleveland.

O. S. M. A. Staff Photos.

Banquet Furnishes Refreshing Pause During Program



7. Dr. G. A. Woodhouse, Pleasant Hill, Dr. H. M. Platter and Dr. J. W. Means, Columbus, pose for camera.
8. Dr. and Mrs. Lincke join enjoyment at banquet-dance.
9. Left to right are Mrs. E. Benjamin Gillette, Toledo, retiring president of the Woman's Auxiliary to the Ohio State Medical Association; Mrs. Luther D. Kice, Garden City, N. Y., national auxiliary president; Mrs. C. W. Kirkland, Bellaire, incoming president of the state organization, and Mrs. George W. Cooperrider, Columbus, president-elect.
10. The orchestra furnished music both warm and sweet.
11. Dr. Robert Pickett (left) and Medical Student Carl Brandfass are shown at the "Male Frog Pregnancy Test" booth which won third prize. Dr. Wynne Silbernagel, Dr. Pickett, Mr. Emil Massa and Mr. Brandfass sponsored exhibit.
12. A group from Clark County are shown at the banquet-dance.
13. The two newly elected members of The Council are Dr. D. W. Heusinkveld of the First District and Dr. M. D. Prugh of the Second District.

was covered by Severino P. Severino of the *Cleveland News* and Walter Lerch of the *Cleveland Press.* The *Columbus Dispatch,* the *Ohio State Journal* and the A. P., U. P. and I. N. S. news services gave especially good coverage to the meeting.

Dr. Carl A. Lincke, Incoming President, was interviewed over Station WELD by Mrs. Rhea McCarty Ahn on the program "Today's Tops." This is a regular program on which Mrs. Ahn interviews the outstanding person of the day in Columbus.

Dr. Jonathan Forman, Editor of *The Journal,* devoted the weekly program "Keep Your Health," on Station WOSU to the Annual Meeting.

Chet Long, news commentator for Station WBNS, covered the meeting thoroughly on the air and included in his broadcasts a walking commentary on the Scientific Exhibits.

SCIENTIFIC EXHIBITS

The Scientific Exhibit, held in the Deshler-Wallick Hotel, was the most extensive of its kind held at an Ohio Annual Meeting. Forty-four separate subjects were presented in graphic form by physicians on various recent developments in medical research.

Dr. C. Joseph DeLor, chairman, and his subcommittee on Scientific Exhibits, was highly commended for their untiring work in making the exhibit a success.

AWARD WINNERS

A committee was appointed to judge the scientific exhibits and to name a first, second and third place winner. Dr. Louis G. Herrmann, chairman of the Committee on Scientific Work, presented the awards to the winners. They were:

First Prize—"Application of Intracardiac Catheterization in the Diagnosis of Congenital Heart Disease," sponsored by Dr. Roy W. Scott and Dr. Henry A. Zimmerman, Cleveland City Hospital and Department of Medicine, Western Reserve University School of Medicine.

Second Prize—"Pneumo-Arthrography of the Knee," sponsored by Dr. W. H. McGaw, Dr. M. D. Sachs and Dr. J. M. Muckley, Department of Orthopedic Surgery and Radiology, Crile V. A. Hospital and Western Reserve University Hospitals and Medical School, Cleveland.

Third Prize—"Male Frog Pregnancy Test," sponsored by Dr. Wynne Silbernagel, Dr. Robert Pickett, Mr. Emil Massa and Mr. Carl Brandfass, Department of Obstetrics, White Cross Hospital, Columbus, and Department of Biological Sciences, Denison University, Granville.

NEW SECTION OFFICERS

At meetings of Scientific Sections of the Ohio State Medical Association held during the Annual Meeting, the following officers were elected.

Section on Anesthesiology—Dr. George F. Collins, Columbus, chairman, to succeed Dr. Carl R. Damron, Mansfield; Dr. Donald E. Hale, Cleveland, secretary, to succeed Dr. Collins.

Section on Eye, Ear, Nose, and Throat—Dr. Norvil A. Martin, Gallipolis, chairman, to succeed Dr. Horace W. Reid, Cincinnati; Dr. Arthur M. Culler, Columbus, secretary, to succeed Dr. Martin.

Section on General Practice of Medicine—Dr. P. B. Wiltberger, Columbus, chairman, to succeed Dr. Ross M. Knoble, Sandusky; Dr. W. B. Recker, Leipsic, secretary, to succeed Dr. J. G. Lemmon, Akron.

Section on Medicine—Dr. Fay A. LeFevre, Cleveland, chairman, to succeed Dr. Leon Schiff, Cincinnati; Dr. Maurice Schnitker, Toledo, secretary, to succeed Dr. LeFevre.

Section on Nervous and Mental Diseases—Dr. Maurice B. Gordon, Cleveland, chairman, to succeed Dr. Dwight M. Palmer, Columbus; Dr. J. Robert Hawkins, Cincinnati, secretary, to succeed Dr. John M. Flumerfelt, Cleveland.

Section on Obstetrics and Gynecology—Dr. Allan C. Barnes, Columbus, chairman, to succeed Dr. Richard D. Bryant, Cincinnati; Dr. Ralph K. Ramsayer, Canton, secretary, to succeed Dr. Barnes.

Section on Pediatrics—Dr. Charles L. Shafer, Mansfield, chairman, to succeed Dr. John Edwin Brown, Jr., Columbus; Dr. Robert B. Hauver, Cleveland, secretary, to succeed Dr. Shafer.

Section on Public Health and Preventive Medicine—Dr. Marion G. Fisher, Oberlin, chairman, to succeed Dr. Thomas E. Shaffer, Columbus; Dr. Floyd P. Allen, Cincinnati, secretary, to succeed Dr. Fisher.

Section on Surgery—Dr. John Holloway, Cleveland, chairman, to succeed Dr. Robert M. Zollinger, Columbus; Dr. Marcus J. Magnussen, Gallipolis, secretary, to succeed Dr. Holloway.

HIGHLIGHTS AND SIDELIGHTS

Dr. Gilman D. Kirk, president of the Columbus Academy of Medicine, representing the host organization, officially opened the meeting of the House of Delegates and welcomed members to Columbus.

* * *

Dr. Kirk issued an invitation on behalf of the Columbus Academy of Medicine for the 1952 Annual Meeting to be held in Columbus. On vote of the House of Delegates the invitation was accepted for an exact date to be set later. Because of the many advance arrangements that must be made for such extensive meetings, the House last year decided to select the place of meetings three years in advance. The 1950 meeting will be held in Cleveland the week of

May 14 and the 1951 meeting in Cincinnati the week of April 22.

* * *

The Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association was held in the Seneca Hotel concurrently with the Annual Meeting of the Association. Officers reported a very successful and profitable session. A complete report of the meeting will be found on page 630 of this issue.

* * *

The House of Delegates sent its condolence to the family of Dr. J. R. Tillotson of Lima, former member of the House, who died suddenly after attending some sessions of the Annual Meeting.

* * *

Because of an increase in membership, the Association is entitled to an eighth delegate to the American Medical Association. Dr. A. A. Brindley was elected to this post, with Dr. H. W. Lehrer of Sandusky, as alternate, to take office January 1, 1950.

* * *

Personnel of the Columbus Academy of Medicine were kept busy relaying telephone messages to physicians at the meeting. Because meetings were scattered throughout two hotels, this task was exceedingly difficult.

* * *

Technical exhibits proved very popular with doctors. The many commercial booths added considerably to the educational features of the meeting, and gave physicians an opportunity to meet some of the representatives behind the products they use and prescribe. Many more supply houses would have been represented if space had been available.

Friends of Land To Hold Conservation Program at Athens

The Eighth Annual Conference on Conservation, Nutrition and Health, sponsored by Friends of the Land, with the cooperation of Ohio University, will be held at Athens on Saturday and Sunday, June 25 and 26.

The theme of the conference will be water in its relationship to conservation, nutrition and health. There will be five discussion periods with the following announced topics: "Water and Human Welfare"; "Water and the Plant"; "The Citizen Attacks the Problem"; "Utilizing Our Surface Waters"; and "Water and Personal Health."

Dr. Jonathan Forman, vice-president of the national organization, will act as presiding officer at most of the conference sessions.

The program will include many nationally known speakers.

Patient Admitted to Hospital Every Two Seconds

During 1948 one patient was admitted to a hospital in the continental United States every 1.9 seconds and a live baby was born in a hospital every 11 seconds, according to the 28th annual report of the Council on Medical Education and Hospitals of the American Medical Association.

Dr. F. H. Arestad, Chicago, associate secretary of the council, and Mary A. McGovern, Chicago, present the report in the May 7 issue of *The Journal of the American Medical Association.* Their figures reveal that in comparison with 1947 the number of hospital beds has decreased from 1,425,222 to 1,423,520 and the number of admissions has increased from 15,829,514 to 16,422,744, a new high in the utilization of hospital service. The previous record was 16,257,402 admissions in 1945.

The apparent discrepancy between increased admissions and decreased number of beds is clarified when the average length of stay per patient in general hospitals is considered. In 1947 the average patient remained 11.4 days in a general hospital; in 1948 he was discharged after 10.5 days, a gain to the patient of about one day. The number of patient days has decreased from 444,288,585 to 444,261,210.

Represented in the report are 6,335 hospitals registered by the American Medical Association, including 1,387 approved for internships and/or residencies in specialties and 2,611 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals is 59 more than reported in 1947.

The decrease in total bed capacity is accounted for entirely in the government group of hospitals, Federal hospitals alone reporting 28,106 beds less than last year. With admissions to government hospitals increasing by 86,147, admissions to civilian hospitals increased by more than 500,000.

Births in hospitals in 1948 totaled 2,794,281, compared with the all-time record of 2,837,139 in 1947.

Of every 1,000 patients entering these hospitals during 1948, 923 were admitted to general hospitals, 18 to neuropsychiatric institutions, two to related institutions, six convalescent homes, seven to eye, ear, nose, and throat institutions, six to tuberculosis sanitariums, six to maternity hospitals, seven to children's, four to industrial, two to orthopedic hospitals, and 13 to isolation units.

First building completed in the Kent State University's current expansion program is the student health center which opened in April. The center has beds for 44 patients.

Annual Meeting Sets Record . . .

Total of 2,608 Attend Program in Columbus To Make Session Largest Ever Held; Names of Members Present and Other Statistics Given.

AN all-time record for attendance was set at the 1949 Annual Meeting of the Ohio State Medical Association, held at the Neil House and Deshler-Wallick Hotel in Columbus, April 19-22.

The record attendance applied to the number of physicians as well as to the total attendance. The total attendance was 2,608, of which 1,533 were members of the Association; 36 were out-of-state physician guests; 126 were interns, residents and Ohio guest physicians; 221 were medical students; 230 were exhibitors; 262 were members of the Woman's Auxiliary, and 200 were miscellaneous guests.

Following are registration figures for the Annual Meetings held from 1919 through 1949; also a breakdown of membership registration by counties, and a list of the names of members who registered.

Registration, 1949 Annual Meeting by Counties and Membership Data

County	Total Membership Dec. 31, 1948	Total Membership April 16, 1949	Annual Meeting Registration
Adams	8	8	3
Allen	91	87	33
Ashland	27	26	8
Ashtabula	50	50	3
Athens	36	32	9
Auglaize	17	16	7
Belmont	54	49	14
Brown	7	5	----
Butler	122	107	11
Carroll	8	9	5
Champaign	19	19	5
Clark	104	105	38
Clermont	26	26	4
Clinton	19	19	10
Columbiana	68	68	15
Coshocton	23	21	11
Crawford	29	32	12
Cuyahoga	1,582	1,538	128
Darke	22	22	8
Defiance	15	15	1
Delaware	18	19	9
Erie	43	41	8
Fairfield	41	42	16
Fayette	13	12	6
Franklin	642	631	385
Fulton	17	18	2
Gallia	20	21	7
Geauga	12	12	----
Greene	31	35	7
Guernsey	28	26	7
Hamilton	942	923	112
Hancock	39	38	15
Hardin	26	28	7
Harrison	13	12	1
Henry	11	11	1
Highland	24	22	10
Hocking	11	11	9
Holmes	9	9	4
Huron	24	24	4
Jackson	12	12	3
Jefferson	58	52	7
Knox	31	32	12
Lake	35	35	2
Lawrence	22	22	6
Licking	59	56	28
Logan	23	22	7
Lorain	127	123	19
Lucas	424	422	59
Madison	15	12	6
Mahoning	234	231	18
Marion	47	36	13
Medina	28	27	3
Meigs	11	12	7
Mercer	19	17	3
Miami	46	44	18
Monroe	4	4	----
Montgomery	392	380	89
Morgan	6	6	2
Morrow	9	8	4
Muskingum	52	51	17
Noble	3	3	1
Ottawa	17	18	5
Paulding	12	10	3
Perry	12	14	5
Pickaway	16	16	8
Pike	9	9	4
Portage	34	33	8
Preble	13	13	1
Putnam	20	19	6
Richland	97	96	29
Ross	45	43	18
Sandusky	46	38	5
Scioto	65	66	13
Seneca	41	41	8
Shelby	18	18	1
Stark	254	253	41
Summit	349	333	53
Trumbull	91	89	9
Tuscarawas	55	49	15
Union	13	14	7
Van Wert	24	24	4
Vinton	2	3	2
Warren	18	17	1
Washington	30	28	5
Wayne	39	41	5
Williams	17	16	4
Wood	33	34	8
Wyandot	13	12	6
Totals	7,331	7,143	1,533

Annual Meeting Registration For 1919-1949, Inclusive

Year	Place	Members	Out-of-State Physicians	Guests	Technical Exhibitors	Total
1919	Columbus	1173	10	264	92	1539
1920	Toledo	860	17	105	80	1062
1921	Columbus	1275	28	104	96	1503
1922	Cincinnati	1066	21	184	70	1341
1923	Dayton	1117	19	202	76	1414
1924	Cleveland	1301	13	180	109	1603
1925	Columbus	1204	17	361	107	1689
1926	Toledo	903	19	120	83	1125
1927	Columbus	1320	17	286	82	1705
1928	Cincinnati	916	27	92	80	1115
1929	Cleveland	1231	15	249	124	1619
1930	Columbus	1241	13	435	86	1775
1931	Toledo	826	13	198	50	1087
1932	Dayton	978	2	201	45	1226
1933	Akron	858	6	160	25	1049
1934	Columbus	1069	9	410	51	1539
1935	Cincinnati	973	17	197	84	1271
1936	Cleveland	1099	14	563	137	1813
1937	Dayton	1103	18	366	64	1551
1938	Columbus	1330	15	619	104	2068
1939	Toledo	1056	15	271	84	1426
1940	Cincinnati	1126	26	323	114	1589
1941	Cleveland—Joint Meeting with A. M. A.					
1942	Columbus	1221	13	527	119	1880
1943	Columbus	544	13	160	----	717
1944	Columbus	830	20	441	130	1421
1945	No Meeting					
1946	Columbus	1262	23	679	157	2121
1947	Cleveland	1502	23	561	328	2414
1948	Cincinnati	1362	43	768	214	2387
1949	Columbus	1533	36	809	230	2608

Members of State Association Registered at 1949 Meeting

Adams County—Sam C. Clark, S. J. Ellison, R. L. Lawwill.

Allen County—Harvey L. Basinger, Walter C. Beery, Wm. H. Beery, Margaret E. Belt, Fred P. Berlin, Maurice Borkon,Homer G. Deerhake, Lowell O. Dillon, F. Miles Flickinger, John A. Glorioso, K. G. Hawver, V. H. Hay, Robert G. Hendershot, Nathan Kalb, Wilford C. Lacock, Charles H. Leech, Wm. B. Ludwig, Walter A. Noble, S. J. Novello, O. S. Robuck, F. D. Rodabaugh, Maurice E. Scheetz, M. D. Soash, Martin M. Sondheimer, David L. Steiner, H. L. Stelzer, Paul J. Stueber, Roger L. Tecklenberg, H. A. Thomas, J. R. Tillotson, B. W. Travis, H. C. Weisenbarger, Carl H. Zinsmeister.

Ashland County—George M. Emery, Robert J. Ferguson, G. Delsher Fridline, Paul E. Kellogg, Glenn Paisley, A. D. Robertson, L. G. Sheets, Wayne C. Smith.

Ashtabula County—Richard C. Irving, A. M. Mills, Robert E. Stoops.

Athens County—Allan A. Baldwin, Hubert H. Fockler, L. A. Hamilton, Theron H. Morgan, Beatrice Postle, Clarence N. Sanders, John R. Sprague, J. L. Webb, Phillip J. Woolworth.

Auglaize County—Clyde W. Berry, Harry Geisler, R. C. Hunter, E. Y. Kuffner, Guy E. Noble, Robert S. Oyer, T. H. Will.

Belmont County—L. D. Covert, D. M. Creamer, David Danenberg, Harry Harris, C. J. Holley, Peter Lancione, Charles V. Lee, Lewis L. Liggett, J. B. Martin, R. H. McCommon, H. M. Metcalf, F. H. Stoup, F. P. Sutherland, E. W. Turner.

Butler County—C. T. Atkinson, Fred Brosius, Mabel E. Gardner, H. Helfman, William H. Henry, W. F. Hume, Vera C. Iber, Harry M. Lowell, Neil Millikin, George T. Riggs, Edward L. Robinson.

Carroll County—T. J. Atchison, Glenn C. Dowell, Carl A. Lincke, Jos. D. Stires, S. L. Weir.

Champaign County—V. R. Frederick, Joseph Friedberger, Francis R. Grogan, D. C. Houser, I. Miller.

Clark County—Robert V. Anderson, Frank W. Anzinger, Jr., Robert D. Arthur, Edwin E. Ash, William D. Beasley, Nelson A. Brandeberry, George L. Clauer, John B. Cooley, Wm. H. Crays, Carl T. Doeing, Charles W. Evans, Ralph Fargotstein, A. A. Gavey, Samuel K. Gerson, E. P. Greenawalt, William J. Habeeb, G. E. Heinrich, D. W. Hogue, Howard H. Ingling, A. Morton Karlan, Wesley E. Knaup, John D. LeFevre, Cecil D. McIntire, Morris B. Martin, Louis H. Mendelson, Wm. H. Miller, William P. Montanus, Lillian M. Posch, Alfred H. Potter, Wm. B. Quinn, Carl H. Reuter, Carl W. Roth, E. W. Schilke, J. H. Shanklin, George A. Smith, R. M. Taylor, Ray M. Turner, S. C. Yinger.

Clermont County—J. M. Coleman, A. J. Mastropaolo, Geo. E. Rockwell, F. S. Skeen.

Clinton County—Robert Conard, R. W. DeCrow, J. H. Frame, Kelley Hale, Nathan S. Hale, Virgil E. Hutchens, Arthur F. Lippert, E. Dalton Peelle, William L. Wead, Edmond K. Yantes.

Columbiana County—Harlow F. Banfield, Jr., Paul H. Beaver, Guy E. Byers, Lea A. Cobbs, Alexander S. Fisher, John A. Fraser, R. T. Holzbach, Wm. J. Horger, Frank M. Lindsay, E. C. Louthan, M. D. McCutcheon, Gladys T. McGarey, Wm. A. McGarey, James R. Moorehead, R. E. Smucker.

Coshocton County—W. R. Agricola, Edmond J. Booth, S. D. Cohen, F. W. Craig, G. A. Foster, R. E. Hopkins, H. W. Lear, A. P. Magness, J. G. Smailes, G. W. Stelzner, E. M. Wright.

Crawford County—Jack W. Arnold, K. H. Barth, Darrel D. Bibler, Russell J. Caton, M. M. Horowitz, Carl J. Ide, John M. Kidd, John S. Kiess, R. M. Malone, Theodore D. Sawyer, G. T. Wasson, Donald R. Wenner.

Cuyahoga County—S. M. Adams, Hugh Amos, Abraham Arons, Lawrence N. Atlas, Frank M. Barry, A. J. Beams, Claude S. Beck, D. G. Benjamin, Franklin A. Benes, Marion E. Black, Spencer Braden, Don D. Brannan, A. S. Broglio, Joseph Edmund Brown, John H. Budd, Donald B. Cameron, David Chambers, Thomas F. Charvat, Austin B. Chinn, Paul Chrenka, Milton B. Cohen, H. N. Cole, Sr., E. N. Collins, John W. Conwell, T. H. Copeland, Henry A. Crawford, George W. Crile, Jr., Joseph A. Crowley, Donald C. Darrah, John H. Dingle, Fred W. Dixon, Eduard L. Eichner, Richard G. Ellis, Elizabeth T. Endicott, A. C. Ernstene, Harold Feil, Joseph L. Fetterman, G. Keith Folger, Shelby G. Gamble, Wm. James Gardner, Thomas H. George, Marion N. Gibbons, Virgil S. Glass, Donald M. Glover, Leona V. Glover, Joseph I. Goodman, Maurice B. Gordon, C. Lee Graber, Jean A. Groh, Donald E. Hale, Carl A. Hamann, John R. Hannan, Meyer Hantman, Maxwell Harbin, Willard E. Hauser, Robert B. Hauver, J. M. Hayman, Jr., Robert W. Heinle, Jacob R. Heller, J. G. Himmel, John W. Holloway, Robt. M. Hosler, Charles L. Hudson, Herman F. Inderlied, Henry J. John, Herbert H. Johnson, Thomas E. Jones, Clifford L. Kiehn, P. J. Kmieck, William B. Landesman, John H. Lazzari, James T. Ledman, Fay A. LeFevre, Irving M. Liebow, S. C. Lind, Robert F. Linn, E. Perry McCullagh, Wilbert H. McGaw, Charles F. McKhann, E. P. McNamee, Regis J. McNamee, James Franklin Martin, John W. Martin, F. R. Mautz, Floyd S. Meck, Paul Motto, A. J. Nemecek, John D. Osmond, Jr., Philip F. Partington, A. J. Pearse, Clayton C. Perry, George W. Petznick, J. C. Placak, Sr., L. A. Pomeroy, R. R. Renner, J. Raymond Ripton, Edw. C. Roy, George W. Ryall, Jr., Maurice D. Sachs, George L. Sackett, B. B. Sankey, Robert W. Schneider, Irving L. Schonberg, R. W. Scott, David W. Shallenberger, William Eggers Smith, W. M. Solomon, A. V. Spaeth, D. K. Spitler, Wess E. Sroub, Robert M. Stecher, Victor L. Tanno, Howard P. Taylor, Robert D. Taylor, C. I. Thomas, M. P. Thomas, Geo. A. Tischler, H. S. Van Ordstrand, Dean C. Varney, John T. Vitkus, Austin Weisberger, R. J. Whitacre, J. M. Wittenbrook, Ralph Wolpaw, Herbert B. Wright, S. Yamshon, Henry A. Zimmerman, Nicholas L. Zinner.

Darke County—Charles E. Geckler, J. E. Gillette, John F. Houser, Maurice M. Kane, F. M. Kissell, John S. Meyers, Paul J. Niederkorn, Gilbert E. Sayle, L. N. Shroder.

Defiance County—D. J. Slosser.

Delaware County—E. V. Arnold, Wm. E. Borden, A. R. Callander, M. S. Cherington, M. W. Davies, Bernard R. Lauer, M. W. Livingston, George J. Parker, F. M. Stratton.

Erie County—Wm. T. Fenker, Herbert F. Kesinger, Ross M. Knoble, David R. Lehrer,

Henry G. Lehrer, Henry W. Lehrer, Francis E. Mahla, W. P. Skirball.

Fairfield County—H. M. Amstutz, James Beesley, Charles F. Clark, William S. Jasper, A. M. Kelley, Victor N. Kistler, A. V. Lerch, G. W. LeSar, Wm. D. Monger, M. E. Nichols, E. B. Roller, S. C. Sneeringer, L. E. Stenger, Chester P. Swett, K. W. Taylor, J. W. Whittus.

Fayette County—Joseph M. Herbert, J. H. Persinger, N. M. Reiff, James E. Rose, James F. Wilson, A. D. Woodmansee.

Franklin County—Luther W. Adams, Kenneth H. Abbott, B. W. Abramson, Louise P. Ainsworth, Marion L. Ainsworth, N. A. Albanese, J. J. Alpers, D. J. Alspaugh, Charles L. Anderson, Homer A. Anderson, Kachig H. Armen, Shirley Armstrong, Ben Arnoff, Emmett W. Arnold, Charles R. Baber, Charles W. Barch, Allan C. Barnes, J. F. Bateman, Earl H. Baxter, Harry C. A. Beach, Jeanne Kathryn Beach, E. C. Beam, James A. Beer, Harold V. Beighley, William H. Benham, C. H. Benson, John H. Blackburn, Betsy Snyder Blackmore, Walter C. Boenheim.

E. T. Bonar, G. H. Bonnell, Jr., G. H. Bonnell, R. W. Bonnell, H. E. Boucher, Charles F. Bowen, Wade D. Bower, William F. Bradley, Richard I. Brashear, Wayne Brehm, Margaret W. Bridwell, B. J. Brief, J. E. Briggs, Richard H. Brooks, Grace Nunemaker Brown, Harold E. Brown, John E. Brown, Jr., John Q. Brown, Sylvia Bubis, Maurice G. Buckles, Olan P. Burt, Alice M. Bustin, Aaron S. Canowitz, B. B. Caplan, J. J. Carter, William H. Carter, Lewis W. Cellio, E. H. Chapin, I. G. Clark, Thomas E. Clark.

H. M. Clodfelter, George D. Clouse, Kenneth A. Clouse, O. L. Coddington, Arthur R. Cohen, George F. Collins, James J. Conn, Constance J. Connors, J. J. Coons, Geo. Cooperrider, D. S. Cowles, Dana W. Cox, Wm. L. Craver, Stuart P. Cromer, John N. Cross, Virgil L. Cross, Andre Crotti, Claude C. Crum, Arthur M. Culler, Thos. R. Curran, George M. Curtis, K. Buell Dahlquist, Robert F. Daly, Horace B. Davidson, Drew L. Davies, Mel A. Davis, Francis W. Davis, Wm. C. Davis, C. Alton Day, Charles J. Deishley.

C. Joseph DeLor, John W. DeVore, Charles A. Doan, R. Frank Donley, J. Quinn Dorgan, Hugh C. Dorr, Edward John Doyle, A. Henry Dunn, J. Mitchell Dunn, A. D. Echert, S. D. Edelman, Edwin H. Ellison, H. W. Federer, Roswell S. Fidler, Frederick C. Finke, Jerome Fisher, T. R. Fletcher, James Foley, Jonathan Forman, Wiley L. Forman, Joseph C. Forrester, Morris J. Fox, Thomas E. Fox, F. C. Frailie, Russell Frantz, Robert L. Frazier, J. C. Frell, Clarence Fry, Huston F. Fulton, Eugene M. Fusco, Clarence M. Gallagher, F. T. Gallen, Joseph M. Gallen, J. M. Gettrost, Ivan S. Gilbert.

H. D. Giles, D. B. Gilliam, F. E. Ginder, Morris Goldberg, Samuel J. Goldstein, Ollie M. Goodloe, Milton L. Goodman, E. J. Gordon, Emilie C. Gorrell, F. W. Gosnell, Mary A. Graber, Grant O. Graves, Helen P. Graves, L. B. Greentree, Wm. R. Griffin, Harry L. Griffith, Paul E. Grimm, Robert C. Grubbs, Morton Hajos, F. E. Hall, Walter H. Hamilton, Esther Handcock, F. C. Haney, D. O. Hankinson, Charles W. Harding, Frances Harding, Warren G. Harding, 2nd., Philip B. Hardymon, H. K. Harris, I. B. Harris.

Louis M. Harris, Wm. B. Harris, Emerson R. Hatcher, John D. Hathaway, Arthur M. Hauer, Emery R. Hayhurst, H. Campbell Haynie, Roger E. Heering, E. B. Heisel, Gabriel C. Heller, Arthur G. Helmick, J. L. Henry, R. Jean Henry, Warren W. Hicks, Samuel Hindman, Willis H. Hodges, Stanley O. Hoerr, Zeph J. R. Hollenbeck, E. L. Hooper, R. B. Hoover, S. M. Horen, Ben C. Houghton, William H. L. Howard, Paul I. Hoxworth, Benjamin Hoyer.

R. B. Hudson, Franklin C. Hugenberger, Hugh B. Hull, Wm. Hutchinson, Robert M. Inglis, W. D. Inglis, B. E. Jacoby, Jay Jacoby, Richard H. Jacques, Arthur G. James, Louis N. Jentgen, Oscar W. Jepsen, A. Beaumont Johnson, Arnold B. Johnson.

D. D. Kackley, Max P. Kanter, H. W. Karrer, Robert A. Keating, A. L. Kefauver, Geo. W. Keil, F. L. Keiser, J. E. Kerschner, Robert A. Kidd, Jr., C. C. Kirk, Gilman D. Kirk, Robert C. Kirk, E. T. Kirkendall, Ben R. Kirkendall, R. W. Kissane, Karl P. Klassen, E. G. Klopfer, Phillip T. Knies, Earl P. Knisely, Albert Kostoff, Leon Kramer, Geo. O. Kress, Roy E. Krigbaum, Willis T. Kubiac, Frank J. Lacksen, Henry B. Lacey, C. C. Landen, Albert B. Landrum, Hedwig Lang, E. C. Lawless, Harry E. LeFever.

D. R. Lewis, Tom Lewis, Bruce E. Lindsey, Sydney N. Lord, Earl D. McCallister, A. B. McConagha, States D. McCoy, J. H. McCreary, Richard L. McFarland, Chas. W. McGavran, Charles W. McGavran, II, Ernie P. McLaughlin, Robert H. Magnuson, T. N. Manos, Louis Mark, Lillian Marks, C. R. Markwood, Bruce G. Martin, W. Eugene Masters, Charles W. Matthews, Frank L. Mauler, Hugh J. Means, John W. Means, Russel G. Means, Richard L. Meiling.

Paul D. Meyer, Wm. G. Meyer, Nicholas Michael, Edgar R. Miller, Wm. H. Miller, M. E. Millhon, H. A. Minthorne, H. R. Mitchell, John H. Mitchell, William F. Mitchell, William B. Morrison, J. L. Morton, Link M. Murphy, Harry E. Myers, Robert D. Myers, G. I. Nelson, G. B. Nessley, James W. Norris, T. W. Novak, W. E. Obetz, Anton Oelgoetz, Arthur L. Osborn, David W. Palmer, Dwight M. Palmer, Paul W. Palmer, Leslie A. Patten, James B. Patterson.

Richard Patton, Chas. W. Pavey, D. Donald Pelliciari, G. W. Pelteson, Ruth Koons Pereny, Claude S. Perry, Paul Q. Peterson, H. M. Platter, Alexander Pollack, C. D. Postle, Joe Price, John A. Prior, Wm. L. Pritchard, I. Darin Puppel, Thomas E. Rardin, Philip J. Reel, K. D. Reichelderfer, William M. Rhodes, John H. Richardson, Frank Riebel, L. C. Roettig, A. Sophie Rogers, R. A. Rogers, Lovell W. Rohr, William K. Romoser.

Philip C. Rond, Sam Rosenfeld, Jr., Leabelle I. Ross, Paul S. Ross, Thomas F. Ross, Norman O. Rothermich, Anthony Ruppersberg, Jr., E. H. Ryan, Daniel G. Sanor, Thos. D. Santurello, Mary Louise Scholl, Henry H. Schwarzell, A. H. Sealy, Harry E. Secrest, Roy J. Secrest, Thomas E. Shaffer, H. Shamansky, Gerhard T. Shearer, John W. Sheetz, Joseph H. Shepard, A. J. Shoemaker, Wynne M. Silbernagel, Jack S. Silberstein, Geo. P. Sims, Robert E. Slemmer, Beecher L. Smith, Trent W. Smith, William A. Smith.

Wm. P. Smith, Sr., Wm. P. Smith, Jr., Elwyn Milton Smolen, Chas. F. Smoot, C. H. Solomonides, R. R. Sommer, Susan P. Souther, Wm. R. Sparling, H. L. Spiro, P. C. Staker, Juliet Stanton, J. S. Stevens, Wm. A. Stoutenborough, Carter R. Straub, Frank F. Tallman, C. B. Tanner, Mabel R. Tarbell, R. B. Taylor, Wells

H. Teachnor, Carl E. Tetirick, Francis W. Thomas, John M. Thomas, R. A. Thornton, D. W. Traphagen, E. V. Turner, Lawrence E. Turton, J. H. J. Upham, Zana Vaile, C. M. Valentine, Richard E. Vance, W. H. Walker, R. H. Wallace, Thos. P. Wangler, H. W. Ward, James H. Warren, Jack H. Welch.

D. E. Wetterauer, Warren E. Wheeler, Daniel J. Whitacre, Harry O. Whitaker, Howard Whitehead, J. W. Wilce, Harlan Wilson, Judson D. Wilson, Ben R. Wiltberger, P. Wiltberger, Charlotte Winnemore, Bruce K. Wiseman, Geo. D. Woodward, H. P. Worstell, Ada V. Wright, Claude-Starr Wright, Donald E. Yochem, Robert E. S. Young, Luke V. Zartman, Richard W. Zollinger, Robert M. Zollinger, Maurice L. Zox.

Fulton County—R. E. Merrill, R. W. Reynolds.

Gallia County—Wm. Lewis Brown, Paul C. Foster, Charles E. Holzer, Jr., M. J. Magnussen, Norvil A. Martin, Homer B. Thomas, Jacob Weinberger.

Greene County—Ray W. Barry, S. C. Ellis, R. D. Hendrickson, C. G. McPherson, H. C. Messenger, Joseph Robert Schauer, A. N. Vandeman.

Guernsey County—Merrit C. McCuskey, H. R. Neeland, J. E. Patton, Robert A. Ringer, George F. Swan, R. M. Swan, James A. L. Toland.

Hamilton County—Nathan R. Abrams, Wm. A. Altemeier, Charles K. W. Ascher, Wm. F. Ashe, E. A. Baber, Charles M. Barrett, M. A. Blankenhorn, Charles S. Blase, Joseph B. Bolin, Byron E. Boyer, Richard D. Bryant, H. F. Conwell, John F. Cronin, A. Harry Crum, J. C. Danahy, William D. DeVaux, Katharine Dodd, Frank R. Dutra, Edward C. Elsey.

Gail S. Englender, Joseph P. Evans, Howard D. Fabing, Carroll J. Fairo, Eugene B. Ferris, Jr., Archie Fine, John Fleming, Joseph J. Flynn, Joseph A. Freiberg, Harry L. Fry, Joseph N. Ganim, Stanley T. Garber, William Germain, Bernard D. Gillman, Leon Goldman, Marjorie A. Grad, David L. Graller, J. Victor Greenebaum, G. M. Guest, Albert L. Haas, Morton Hamburger, Jr., John R. Harding, Warren Hattendorf, C. E. Hauser, J. Robert Hawkins.

Louis J. Hendricks, Louis G. Herrmann, D. W. Heusinkveld, Francis F. Heyroth, Raymond L. Hilsinger, Leon S. Hirsh, Richard B. Homan, Charles Hoyt, J. Robert Hudson, D. E. Jackson, Jerome N. Janson, Daniel V. Jones, Robert A. Kehoe, Lee Keidel, Roy L. Kile, Robert H. Kotte, Max Krakauer, Lloyd E. Larrick, Joseph Lindner, W. H. Lippert, Max L. Lurie, Herbert P. Lyle, Robert A. Lyon, Edward J. McGrath, Johnson McGuire, Esther Marting.

Elmer R. Maurer, George A. Meyers, H. Marie Miller, Arthur Mirsky, James H. Mithoefer, Roland E. Nieman, J. P. Owens, Geo. F. Patterson, C. P. Pennington, Virgil A. Plessinger, Joseph J. Podesta, Horace W. Reid, Morton F. Reiser, A. C. Renz, Robert C. Rothenberg, Eugene L. Saenger, Leon Schiff, Stuart A. Schloss, A. L. Schwartz, Wm. T. Shriner.

Vinton E. Siler, Leo A. Smyth, Louis Sommer, Henry A. Springer, E. V. Stewart, Victor Strauss, Cecil Striker, E. O. Swartz, Wm. S. Terwilleger, William C. Thornell, John L. Tyler, Richard W. Vilter, T. H. Vinke, Josef Warkany, Calvin F. Warner, A. A. Weech, Arthur W. Wendel, Daniel A. Whalen, Carl A. Wilzbach, Ling G. Wong, M. M. Zinninger, Albert R. Zoss.

Hancock County—David H. Greegor, J. R. Janney, Dwight J. King, Henry P. Koehler, John H. Marshall, E. E. Rakestraw, Ralph E. Rasor, R. S. Rilling, John F. Roth, H. L. Selo, T. R. Shoupe, T. A. Spitler, Robert E. Traul, Harold K. Treece, Frank M. Wiseley.

Hardin County—W. H. Baldwin, R. A. Dietrich, Floyd M. Elliott, Stephen Philip Churchill, A. W. Sage, R. G. Schutte, R. H. Zeis.

Harrison County—Carl F. Goll.

Henry County—B. L. Johnson.

Highland County—John G. Anderson, J. C. Bohl, J. Martin Byers, Clifford G. Foor, Lena Holladay, W. M. Hoyt, H. H. Lowe, Leland D. McBride, W. C. Martindill, W. B. Roads.

Hocking County—L. W. Starr-Boocks, H. M. Boocks, M. H. Cherrington, J. W. Doering, Chas. T. Grattidge, R. C. Jones, Walter B. Lacock, H. G. Southard, Owen F. Yaw.

Holmes County—A. J. Earney, Luther W. High, Owen F. Patterson, N. P. Stauffer.

Huron County—C. J. Cranston, R. C. Gill, O. J. Nicholson, W. R. Roasberry.

Jackson County—J. S. Hunter, Elizabeth C. Innis, Earl J. Levine.

Jefferson County—John Y. Bevan, David S. Greenberg, J. A. Haney, Jacob Mervis, M. H. Rosenblum, Warren G. Snyder, Albert E. Winston.

Knox County—Joseph W. Allman, C. E. Cassaday, C. L. Harmer, R. H. Hoecker, H. Clifford Johnson, Raymond S. Lord, Henry T. Lapp, Alexander S. Mack, O. W. Rapp, Irville S. Rian, Delbert C. Schmidt, Julius Shamansky.

Lake County—R. K. Miles, B. S. Park.

Lawrence County—F. D. Campbell, Wm. A. French, W. F. Marting, Thos E. Miller, V. V. Smith, W. Ray Swango.

Licking County—C. G. Bozman, A. S. Burton, James F. Busby, Geraldine H. Crocker, Gerald A. Erhard, K. J. Fleisch, Carl M. Frye, Donald E. Goley, G. A. Gressle, Paul C. Grove, Robert C. Haubrich, R. W. Jones, R. G. Mannino, R. C. Mauger, C. H. Miller, Thos. E. Morgan, Wm. H. Morgan, James K. Nealon, Carl L. Petersilge, Arnold D. Piatt, Ralph E. Pickett, R. G. Plummer, James H. Pollock, Dale E. Roth, W. E. Shrontz, D. A. Skinner, Louis J. Tilton, Robert S. Young.

Logan County—C. L. Barrett, Byron B. Blank, Hobart L. Mikesell, W. F. Mills, C. K. Startzman, Chas. H. Thompson, F. Blair Webster.

Lorain County—Theodore Berg, W. K. Brubaker, Joseph Cicerrella, Joseph M. DeNardi, John B. Donaldson, R. J. Emslie, Marion G. Fisher, Franz Gruen, Geo. A. Hoke, J. C. MacDermott, Jr., Chas. R. Meek, Bristow C. Myers, S. D. Nielson, A. J. Novello, V. G. Peiffer, D. A. Russell, R. L. Shilling, Joseph M. Strong, N. A. Tillman.

Lucas County—Warren A. Baird, Carl H. Bayha, A. L. Bershon, P. E. Bethards, George T. Booth, A. A. Brindley, H. A. Brunsting, Edward L. Burns, Henry A. Burstein, F. W. Clement, I. R. Cohn, Burgess E. DeMuth, Rudolph Diethelm, Fred M. Douglass, Crawford L. Felker, J. N. Fidelholtz, Karl D. Figley, C. R. Forrester, David C. Frick, E. B. Gillette, Norris W. Gillette, Wendell Green, A. P. Hancuff, Arthur M. Harrison, Elmer Haynes, John F. Hillabrand, Paul Hohly, Richard Hotz, Wm. M. Jennings, T. C. Kiess, Rollin Kuebbeler.

George H. Lemon, John A. Lukens, E. E. Lyon, Otto K. Muhme, Carll S. Mundy, Foster Myers, F. N. Nagel, Anna May Newton, Leonard Nippe, Spencer W. Northup, Eugene A. Ockuly, John-

ston F. Osborne, Louis E. Payne, Willis S. Peck, R. W. Pocotte, Alfred Edward Rhoden, Maurice A. Schnitker, Max T. Schnitker, Leopold W. Siberd, J. W. Smythe, Roscoe H. Snyder, M. M. Thompson, Jr., Oliver E. Todd, C. W. Waggoner, E. F. Ward, Jr., A. M. Weilbauer, Morris Weinblatt, Ralph L. Zucker.

Madison County—Ernest S. Crouch, R. W. E. Irwin, Herman E. Karrer, J. M. Morse, F. E. Rosnagle, G. C. Scheetz.

Mahoning County—Albert Brandt, Frederick S. Coombs, A. J. Fisher, Paul J. Fuzy, Robert J. Heaver, John Heberding, Joseph P. Keogh, John N. McCann, Dean Nesbit, Robert E. Odom, G. A. Parillo, Arthur E. Rappoport, Edward J. Reilly, A. B. Sherk, William M. Skipp, Ivan C. Smith, E. J. Wenaas, W. P. Young.

Marion County—E. L. Brady, Maud L. Bull, Bret B. Hurd, Samuel E. Katz, M. K. Marshall, Frederick T. Merchant, A. E. Morrison, H. K. Mouser, B. D. Osborn, Herman S. Rhu, Warren C. Sawyer, N. Sifritt, Wm. H. Whitehead.

Medina County—Herbert F. Cowgill, J. K. Durling, T. Victor Kolb.

Meigs County—Selim J. Blazewicz, Raymond E. Boice, Roger P. Daniels, W. S. Ellis, P. A. Jividen, Chas. J. Mullen, John Philson.

Mercer County—George H. McIlroy, E. J. McLaughlin, Rudolph G. Schmidt.

Miami County—William N. Adkins, John F. Beachler, Sr., Don F. Deeter, Howard Farmer, Russell W. Gardner, Roger M. Gove, C. A. Halderman, Berton M. Hogle, Emory R. Irvin, V. H. Kemper, M. C. Kiser, Kenneth F. Lowry, E. G. Puterbaugh, John T. Quirk, W. W. Trostel, John M. Wilkins, W. T. Wilkins, Jr., G. A. Woodhouse.

Montgomery County—William Abramson, I. H. Altenburg, Wm. R. Althoff, S. H. Ashman, Robert C. Austin, J. K. Bailey, Calvin L. Baker, Lynne E. Baker, C. C. Borden, Austin J. Brogan, R. N. Brown, Robert A. Bruce, Wm. B. Bryant, C. E. Burgett, Rudolph H. Caplan, A. W. Carley, Homer D. Cassel, Phillips R. Champion, Sam S. Chudde, C. E. Clark, E. F. Conlogue, A. D. Cook, Leo R. Courtright, R. Dean Dooley, G. L. Erbaugh, R. K. Finley, J. R. Gersack.

James T. Gilboy, Francis V. Grice, John Emmert Groff, R. L. Haas, Wm. H. Hanning, Zelda E. Heiney, Jerome P. Hochwalt, N. R. Hollister, Roy S. Binkley, Mason S. Jones, Reid P. Joyce, Jos. S. Koehler, Richard S. Koehler, A. F. Kuhl, Kenneth Kurtz, Howard Lauer, W. M. Leavenworth, T. L. Light, Maurice M. Linder, M. V. Lingle, Louise C. Loeber, A. P. McDonald, W. M. McLin, R. C. McNelly, A. W. Marcovich, George I. Martin, M. B. Menke, L. J. Newell, T. E. Newell, George A. Nicoll, Julius Ohlmann, Melvin Oosting.

C. Clarkson Payne, Neal C. Perkins, Richard A. Pfarrer, Jos. H. Prince, Merrill D. Prugh, W. A. Ricketts, Cecil F. Rust, Louis Ryterband, James L. Sagebiel, Richard T. Sauer, Harry B. Schiffer, Richard J. Schneble, James M. Shaffer, Everett W. Shank, Thomas P. Sharkey, Ned Shepard, Henry Snow, Roscoe H. Spitler, Paul R. Stauffer, Jerome S. Surdyk, W. B. Taggart, John F. Torrence, Paul Troup, James G. Tye, Thomas A. Weaver, Giles Wolverton, John R. Woodruff, Orville Wright, Paul L. Yordy, Robert E. Zipf.

Morgan County—Henry Bachman, C. E. Northrup, Sr.

Morrow County—Stanley L. Brody, Joseph P. Ingmire, Lowell Murphy, F. H. Sweeney.

Muskingum County—W. L. Cruise, I. W. Curtis, W. B. Devine, P. H. Elliott, Myron A. Freilich, Beatrice T. Hagen, Paul A. Jones, H. B. Kaufman, Lester Lasky, A. C. Lawrence, M. A. Loebell, George C. Malley, Robert S. Martin, A. C. Ormond, Flora M. Pedicord, Donald A. Urban, Earl B. Zurbrugg.

Noble County—Edward G. Ditch.

Ottawa County—H. O. Beeman, Geo. A. Boon, Harriet B. Howes, A. D. Miessner, Cyrus R. Wood.

Paulding County—G. L. Doster, D. E. Farling, R. H. Mouser.

Perry County—Edgar D. Allen, O. D. Ball, C. B. McDougal, R. W. Miller, W. D. Porterfield.

Pickaway County—D. V. Courtright, Marion D. Gamble, G. R. Gardner, Geo. W. Heffner, Walter F. Heine, H. D. Jackson, V. D. Kerns, E. S. Shane.

Pike County—R. M. Andre, C. L. Critchfield, Paul H. Jones, W. L. McCaleb.

Portage County—Myrtle Collins-Dineen, E. M. Kauffman, Elizabeth A. Leggett, Edward T. Meacham, Richard C. Neely, Jr., Bernard H. Nichols, Myron S. Owen, Stanley B. Peters.

Preble County—E. P. Trittschuh.

Putnam County—Dwight L. Becker, Donald B. Lucas, H. A. Neiswander, M. W. Palestrant, W. B. Recker, Milo B. Rice.

Richland County—Oren A. Beatty, C. H. Bell, Wendell M. Bell, Paul A. Blackstone, Wallace H. Buker, C. F. Curtis, Carl R. Damron, Joseph B. Edelstein, Darrell B. Faust, Robert L. Garber, Charles L. Hannum, J. S. Hattery, H. G. Knierim, John F. McHugh, Ernest B. Mainzer; Lizabeth Mainzer, Earl C. Mast, Wilmot W. Pierce, H. F. Plaut, Myron S. Reed, R. P. Scott, Geo. J. Searle, Charles L. Shafer, Erling A. Smedal, J. L. Stevens, Henry Stiles, Albert H. Voegele, F. M. Wadsworth, Harry Wain.

Ross County—Edwin H. Artman, R. C. Bane, R. E. Bower, Geo. W. Cooper, Richard L. Counts, Harold M. Crumley, Theo. Cutright, H. E. Harman, Ralph W. Holmes, Walter E. Kramer, R. E. Lightner, A. E. Merkle, F. W. Nusbaum, M. D. Scholl, E. Paul Shepard, Robert E. Swank, Adolph Wolff, G. Howard Wood.

Sandusky County—C. M. Cooper, R. Allen Eyestone, Chas. L. Fox, Harold L. Keiser, L. A. Pokerr.

Scioto County—Geo. D. Blume, Clyde W. Everett, Clyde M. Fitch, Ross M. Gault, A. P. Hunt, J. P. McAfee, T. G. McCormick, Gilbert Micklethwaite, G. E. Neff, Wm. A. Quinn, William E. Scaggs, Charles S. Vinson, Philip D. Weems.

Seneca County—Henry Lyman Abbott, Wm. R. Funderburg, L. C. Gerlinger, John M. Leahy, Paul L. Leahy, E. F. Ley, W. W. Lucas, V. L. Magers.

Shelby County—Russell L. Wiessinger.

Stark County—L. E. Anderson, Edw. Arnold, James H. Bahrenburg, A. R. Basinger, H. H. Bowman, Harold J. Bowman, Roy H. Clunk, Cleon C. Couch, Lloyd L. Dowell, William E. Elliott, D. T. Feiman, Delmar R. Gard, Verl Z. Garster, Ian B. Hamilton, Mark G. Herbst, Edward A.

Hill, Homer I. Keck, Douglass S. King, George L. King, J. B. Klein, J. M. Muckley.

Keith C. Noble, W. R. Portz, J. Edwin Purdy, H. P. Ramsayer, R. K. Ramsayer, Edward C. Reno, Elden M. Rowland, R. L. Rutledge, William E. Sag, Raymond T. Saxen, W. J. Slasor, Clarence V. Smith, R. G. Spitzer, Fred H. Stires, R. E. Tschantz, G. D. Underwood, Louis L. Weiss, Geo. N. Wenger, George M. Wilcoxon, J. S. Williams.

Summit County—Robt. T. Allison, Jr., C. H. Bair, E. C. Banker, Robert M. Bartlett, J. H. Bond, M. F. Bossart, Earl W. Burgner, R. L. Burtin, Paul E. Cheek, Derwin D. Daniels, Paul A. Davis, F. W. Dixon, Arthur Dobkin, George R. Dochat, William A. Friend, Theodore V. Gerlinger, N. G. Gordon, R. A. Gregg, Carrie A. Herring, Roy F. Jolley, H. A. Karam, James G. Kramer, J. G. Lemmon, E. S. Lyon, C. T. McCormish, D. M. McDonald, Frank M. McDonald, L. B. Mehl, John E. Monnig, Frank T. Moore, H. E. Muller, Ellis L. Noble, Carl C. Nohe, Frank Oldenburg, A. P. Ormond, Arnold C. Peter, Roger E. Pinkerton, Fred K. Read, David J. Roberts, Fowler B. Roberts, J. Paul Sauvageot, H. Vern Sharp, Hazel P. Simms, Alva R. Spindler, J. E. Springer, L. I. Thomas, Edward L. Voke, Kurt Weidenthal, N. E. Wentsler, C. F. Wharton, Rex H. Wilson, L. A. Witzeman, H. E. Woodbury.

Trumbull County—E. P. Adams, J. N. Caldwell, E. G. Caskey, E. G. Kyle, Roger H. McCaughtry, Ralph E. Meacham, Clyde W. Muter, Robert P. Ostergard, S. J. Shapiro.

Tuscarawas County—James S. Adler, John C. Blinn, B. O. Burkey, Jay W. Calhoon, W. W. H. Curtiss, Clark M. Dougherty, D. H. Downey, M. W. Everhard, R. J. Foster, Daniel D. Hostetler, Wm. E. Hudson, M. W. Johnson, C. J. Miller, Russell L. Oyer, Harold F. Wherley.

Union County—John L. Boylan, Walter R. Burt, Fred C. Callaway, Bernard E. Ingmire, A. M. Johnston, P. D. Longbrake, E. J. Marsh.

Van Wert County—Thomas L. Edwards, Roland H. Good, John E. Scheidt, R. E. Shell.

Vinton County—Richard E. Bullock, H. D. Chamberlain.

Warren County—Orville L. Layman.

Washington County—Clarence E. Ash, K. E. Bennett, Ford E. Eddy, Donald E. Hughes, W. D. Turner.

Wayne County—Lyman A. Adair, Everett C. Burgess, F. C. Ganyard, Thomas N. Geracioti, Vincent C. Ward.

Williams County—C. G. Goll, H. R. Mayberry, P. G. Meckstroth, H. W. Wertz.

Wood County—G. C. Aurand, H. W. Dierksheide, E. D. Foltz, H. W. Mannhardt, Paul F. Orr, William S. Rothe, Frank W. Taylor, R. W. Whitehead.

Wyandot County—J. Craig Bowman, Albert M. Mogg, B. A. Moloney, Clarence B. Schoolfield, F. M. Smith, John M. Thompson.

Dr. James A. Doull, formerly of Cleveland, and recently medical director, U. S. Public Health Service, has been appointed as medical director of the Leonard Wood Memorial (American Leprosy Foundation) and will have his office at 1832 M St., N. W., Washington, D. C.

National Eclectic Association To Meet in Cincinnati, June 21-23

The Annual Meeting of the National Eclectic Medical Association to be held at the Netherland Plaza Hotel in Cincinnati, June 21-23, will be a memorable event in the history of this century-old organization.

The meeting will be featured by the dedication of plaques commemorating the 100th anniversary of the formation of the National Eclectic Medical Association and the 100th anniversary of the birth of Professor John Uri Lloyd, for many years one of the leaders in Eclectic medicine.

Registration for the meeting will start on the morning of Monday, June 20, but the first session will not be held until the following day. Dr. Cloyce Wilson of Cincinnati, chairman of the local committee, will call the meeting to order.

Dr. H. A. Martin, Gratiot, president of the Ohio State Eclectic Medical Association, will give an address of welcome. After the luncheon, the meeting will be called to order by Dr. R. B. Taylor, Columbus, the president-elect.

Among physicians who will present papers will be the following from Ohio: Dr. Taylor; Dr. John H. Payne, Cincinnati; Dr. Carl G. Hoffman of Cincinnati; and Dr. W. H. Stoutenborough of Columbus.

Appointments to Ohio Advisory Council Are Made

Dr. John D. Porterfield, director of the Ohio Department of Public Health, announced that Governor Lausche had made four appointments to the Ohio Advisory Council to the Department.

Dr. J. F. Bateman, superintendent of Columbus State Hospital, was appointed to succeed Dr. Edward J. Humphreys. Mrs. Frances Hoffman, secretary to the Columbus Metropolitan Health Council, was named to succeed Miss Doris Chandler of Dayton. Msgr. Robert E. Maher of Toledo and Dr. M. F. Steele of Cincinnati were reappointed.

Births Remain High in 1948

The second largest number of births in the history of this country occurred during 1948, according to the Public Health Service.

The number of live births registered during 1948 was estimated at 3,559,000 or only about 4 per cent below the all-time high of 3,699,940 for 1947. Of even greater significance are the figures which take into consideration the unregistered births. The total number of births (registered and unregistered combined) was estimated at 3,715,000 for 1948 and 3,876,000 for 1947. Only eight years earlier, in 1940, the last pre-war year, the figure was 2,558,000.

On the Firing Line . . .

Shots At Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"The facts, simply put, are that about one-eighth of the cost of the (National Health) Service are met from the insurance contributions; that an average of about 8½d. of the 4s. 11d. (usual employee's weekly contribution) goes to the Health Service, the remainder going to unemployment benefit, sickness benefit, widow's pension, maternity benefit, retirement benefit, etc.; that the general practitioner receives about 4½d. a week, roughly 1d. from the weekly contribution and 3½d. from taxes."—*The Secretary Reports, British Medical Journal, April 16, 1949.*

* * *

"Mr. Truman's aides in the state medicine drive are conducting a campaign which for tricky argument, specious reasoning, and fractional truths hasn't been equalled since the stirring days of the fight to pack the Supreme Court. Chief among these is Federal Security Administrator Oscar Ewing who has issued a booklet, 'The Nation's Health,' purporting to prove that only socialized medicine can pull American public health out of an appalling slough of despond."—*The Columbus Dispatch.*

* * *

"The cost of the social services was the recurrent theme in Sir Stafford Cripp's Budget speech. He rebuked those who, while demanding costly social services, at the same time asked for reduction of taxation.

". . . The National Health Service is an important part of what the Chancellor called 'a permanent and continuing obligation which automatically increased as those services inevitably developed.' Seeing, and perhaps fearing, this automatic and inevitable increase, he hinted that next year he might have to impose, 'some special charge or tax in connection with health services . . . this might help to make people more economical in their use of the services.' "—*British Medical Journal, April 16, 1949.*

* * *

"Instead of saying that people can't afford medical care, it would be far truer to say that people prefer to buy something else."—*Mr. H. M. Kieswetter, in address before the American Pharmaceutical Manufacturers Association.*

"The next move will be socialized life insurance, to make it a part of the national pension system. Step by step the process will go on. Government invasion of insurance, or of any other business, is like creeping paralysis. It takes over one operation after another until the people have lost control of everything."—*Aaron M. Sargent, San Francisco attorney.*

* * *

"I have talked to scores of doctors, many of them devoted to their patients. Their case against compulsory health insurance boils down to three points: (1) It will not make medical care better, but worse; (2) it is not insurance, but a waste of money; (3) it will not reduce sickness nor save lives."—*Greer Williams in Nation's Business, March, 1949.*

* * *

"The Labor party said today it will put five more big businesses under public ownership if it wins Britain's 1950 election.

"The party's executive committee in a 25,000 word policy statement marked cement, life insurance, sugar making and refining, private and municipal water companies and 'all suitable minerals' for nationalization."—*Associated Press Dispatch from London, April 12.*

* * *

"Socialized medicine necessarily means regimentation for doctors, dentists, and nurses. But why heal an improperly fed child, and then return him to his parents? More government control over diet is a next step—over parents, too, perhaps. Housing, clothing, and recreation also relate to good health, likewise pointing toward more controls."—*Benjamin B. Kendrick, in Nation's Business, May, 1949.*

* * *

"We are not in favor of any compulsory system which might lead to Federal control of medical practice, to regimentation of patients and physicians, to extinction of private initiative and of voluntary health agencies.

"We do not believe that this is the time to saddle a compulsory health program on the American people. We do not believe that the

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voluntary system has failed, for who will deny that here in America we now have the best health service available anywhere. It should be extended not by compulsion, but by voluntary means."—*Elyria Chronicle Telegram.*

* * *

"There are at least ten communist fronts working for social insurance. Do you think they are trying to improve conditions in the United States? Do you have the idea they are trying to build a strong nation able to stand up against Soviet Russia?

"No, the key people in these communist fronts realize that compulsory health insurance will bankrupt the United States, as it has exhausted the finances of every nation which has tried that experiment. They know disorder will follow. They realize that controls established under that system will be available to set up a dictatorship."—*Aaron M. Sargent, San Francisco attorney, on the Pettengill Hour, American Broadcasting Company.*

* * *

"A famous New Zealand physician, recently in Canada, stated: 'Public medicine in New Zealand is a disaster. It is turning our people into a race of hypochondriacs.'

"It is also breaking the public bank. The American Congress has not even begun to think what public medicine will do to the public purse and public health. When and if it does, it will find another way to meet real needs."—*Dorothy Thompson.*

* * *

"Elizabeth Wilson, author and student of socialized medicine, watched the British system in operation last year. She reports that many doctors are seeing and attempting to prescribe for from 40 to 75 patients a day. She tells of at least one doctor who frequently sees 120 patients in his office during a four-hour period.—*Compulsory Health Insurance, A Message From Your Doctor, Published by the A. M. A.*

* * *

"What can be more simple than the relationship of physician and patient? Why employ thousands of people to collect the doctor's bill? Senator Murray's plan would result in enormous dislocation of our present methods by creating boards to administer the monstrosity, taking the time of the doctor which should be devoted to the care of the sick, to making out of reports that would do no one any good . . ."—*Dr. David W. Heusinkveld, President, Cincinnati Academy of Medicine, in the Cincinnati Enquirer.*

* * *

"The loudest cries for socialized medicine have come from the Government planners, always seeking another experimental toy; the Socialists, who openly advocate absolute government control; the Communists, who support any proposition that may disrupt our economy and ripen our country for revolution; the loafers, who seek any opportunity to get something for nothing."—*Senator Allen Ellender (D), Louisiana.*

* * *

"(The proponents of Compulsory Health Insurance) dislike to be pinned down on such practical matters as the cost of their scheme. Numerous experts on medical economics, public health, and taxation have predicted ultimate annual costs ranging from 10 to 18 billion dollars, a 6 per cent payroll tax just to get the system in operation, and an eventual paycheck tax rate of 10 or 12 per cent."—*Senator Harry P. Cain (R), Washington.*

* * *

"The introduction of compulsory social insurance in cases of sickness, or compulsory social insurance in cases of unemployment, means that the workers must be subject to examinations, investigations, regulations, and limitations. Their activities must be regulated in accordance with the standards set by governmental agencies. To that we shall not stand idly by and give our assent."—*Samuel Gompers, in an Address Delivered in Washington, D. C., December 5, 1916, Published in Insurance Economics Surveys.*

* * *

"We think we shall get along faster and better if the advocates of better medical care for more people get this lurking desire for Socialist experimentation out of their heads. Some of it is there now to confuse the issue.

"We think also that individual initiative is as good for medicine as it is for industrial production. We think the American standard of living is the highest in the world because every ambitious child is free to develop all his capacities and to get paid for his services. We see no reason to exclude doctors from the benefits of a free enterprise system."—*Editorial, Collier's, May 14, 1949.*

* * *

"Call it what they may—and deny it as they will—it still is socialized medicine. It isn't 'insurance' in that sense of the term to which an insurance-buying public is accustomed; for not a policy will be issued. All that would happen is that the Federal Government would take over supervision of the medical field, via tax money drawn from the citizens on a compulsory basis for that purpose, and regulate the relations between the doctors—or hospitals, as the case might be—and the patients."—*Nashville Banner.*

Woman's Auxiliary . . .

Ninth Annual Meeting Is Held in Columbus, Concurrently With That of Association; Officers Elected; Attendance Reaches Total of 262

THE ninth annual meeting of the Woman's Auxiliary to the Ohio State Medical Association was held from Tuesday, April 19, to Thursday, April 21, inclusive, at the Seneca Hotel, Columbus. Mrs. D. J. Alspaugh, convention chairman, and Mrs. Wayne Brehm, co-chairman, through their tireless efforts produced a highly successful and noteworthy convention.

TUESDAY'S PROGRAM

The pre-convention Board meeting was held Tuesday morning with the president, Mrs. E. Benjamin Gillette of Toledo, presiding. Annual reports of officers, chairmen and directors were given. A luncheon of the Board of Directors followed this meeting.

The formal opening session of the House of Delegates took place at 1:30 p. m., with Mrs. Gillette presiding. The invocation was given by Reverend Gordon S. Price, assistant rector, Trinity Episcopal Church. The pledge of loyalty was presented by Mrs. Roswell S. Fidler, and Dr. Gilman Kirk, president of the Columbus Academy of Medicine, welcomed the doctors' wives to Columbus and the ninth annual meeting. Mrs. A. D. Cook, president of the Montgomery County auxiliary, gave the response for the convention.

It was at this session that Mrs. Gillette, the president, presented her report for the year, and expressed her deep appreciation for the splendid cooperation she had been accorded throughout her year. Reports of the other officers and chairmen followed that of Mrs. Gillette.

The Columbus Gallery of Fine Arts was the scene, later that afternoon, of a tea held in honor of Mrs. A. A. Brindley, Mrs. Wayne Brehm and the past presidents of the State of Ohio. The Chapel Choir of Capital University with Ellis Emanuel Snyder conducting, presented a truly inspiring musical program.

WEDNESDAY'S PROGRAM

The second session of the House of Delegates was called to order Wednesday morning by the president, Mrs. Gillette. Reports of the special committees were given. There was the first reading of the Nominating Committee, and the first reading of recommendations of the Board. Then followed the two-minute reports of the county presidents—in spite of the necessity for brief reports, it was a wonderful tribute to the work the local auxiliaries are doing to hear the many worth-while and outstanding activities the doctors' wives are sponsoring.

At twelve o'clock noon, the impressive "In Memoriam" service was held under the direction of Mrs. George W. Cooperrider. Assisting her were Mrs. Joseph Ridgeway, Mrs. Richard Zollinger, Mr. Kenneth R. Keller, baritone, director of music, Columbus Public Schools, and the Reverend Carl Heminghaus, pastor of Grace Lutheran Church.

PRESIDENT'S LUNCHEON

The President's luncheon honored Mrs. Gillette and Dr. A. A. Brindley, president of the Ohio State Medical Association. The visiting presidents and presidents-elect of the States of Pennsylvania and Indiana were introduced, as was the Advisory Council of the Ohio State Medical Association—Dr. H. M. Clodfelter, Dr. Paul A. Davis and Dr. J. Craig Bowman. The guest speaker, Mr. Hugh Brennaman of Detroit, public relations director of the Michigan State Medical Association, gave a dynamic talk, dealing primarily with President Truman's health insurance plan and socialized medicine.



Mrs. C. W. Kirkland (left), incoming president, receives the gavel from Mrs. E. Benjamin Gillette, retiring president, at the Annual Meeting in Columbus.

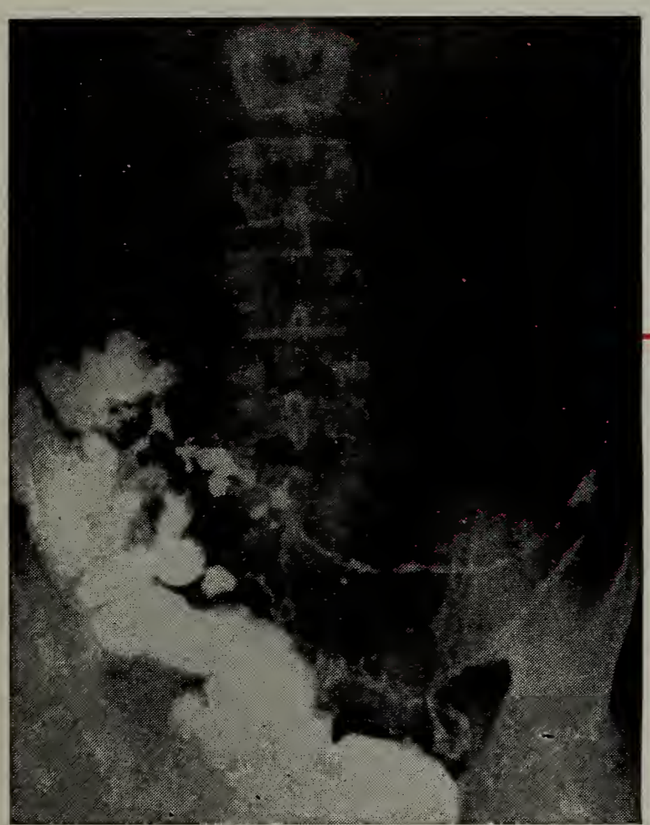
SEMINARS

Repeating last year's successful "seminar session," the auxiliary members attended one of three seminar round-table discussion groups held

TREATMENT OF CONSTIPATION IN mucous colitis

"The treatment of the constipation in mucous colic does not differ from the treatment of uncomplicated constipation. It is, as always, of great importance to avoid irritating aperients, ... The stools should be rendered soft and more bulky and therefore more easy to expel with . . . and unirritating vegetable mucilages."

—Hurst, A., in Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 692.



MUCOUS COLITIS. In this x-ray is shown the distinctive string-like appearance of the descending portion of the lower bowel in mucous colitis, a condition frequently accompanying severe degrees of spastic or atonic colon. In the sagittal section is shown the over-secretion of mucus adhering to the bowel wall.



By providing soft, demulcent, water-retaining, mucilloid bulk, Metamucil—the "smoothage" treatment of constipation—promotes a return to normal elimination.

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for the benefit of the local auxiliaries. The Administration seminar was held under the direction of Mrs. Carll S. Mundy; the Public Relations seminar under the direction of Mrs. Farrell Gallagher and Mrs. Paul A. Davis; the Organization seminar under the direction of Mrs. C. W. Kirkland. These sessions provide an excellent opportunity for answering the very many, ever-present questions cropping up in the local auxiliaries.

THURSDAY'S PROGRAM

The third session of the House of Delegates was called to order Thursday morning by the president, Mrs. Gillette. The unfinished reports of county presidents, and unfinished business were taken care of. Delegates to the national Auxiliary Convention were elected. Then came the Big Announcement—the two winners of the Credits and Awards prizes, based on the "point system" used for the first time last year. The first prize went to Clark County, Mrs. Frank Anzinger, president; the second prize to Allen County, Mrs. V. H. Hay, president.

The report of the nominating committee was presented by Mrs. Harold K. Mouser, chairman.

NEW OFFICERS AND DIRECTORS

The new officers and directors elected include: president, Mrs. C. W. Kirkland, Bellaire; president-elect, Mrs. George Cooperrider, Columbus; vice-president, Mrs. Paul Woodward, Cincinnati; recording secretary, Mrs. C. H. Bell, Mansfield; corresponding secretary, Mrs. R. H. McCommon, Shadyside; treasurer, Mrs. A. P. Hancuff, Toledo; past president, Mrs. E. Benjamin Gillette, Toledo.

Directors: Mrs. Azel Ames, Jr., Hamilton; Mrs. E. P. Greenawalt, Springfield; Mrs. Harold K. Mouser, Marion; Mrs. Cyrus Wood, Port Clinton; Mrs. S. C. Lind, Cleveland; Mrs. J. H. Bahrenburg, Canton; Mrs. Carl Goehring, Steubenville; Mrs. Chester P. Swett, Lancaster; Mrs. George Obrist, Portsmouth; Mrs. N. M. Reiff, Washington Court House; Mrs. C. E. Swanbeck, Huron.

Chairmen of standing committees: Finance, Mrs. E. Benjamin Gillette, Toledo; Legislation, Mrs. C. S. Mundy, Toledo; Publicity, Mrs. S. L. Meltzer, Portsmouth; *Hygeia*, Mrs. Paul A. Davis, Akron; Program, Mrs. R. S. Fidler, Columbus; Organization, Mrs. George Cooperrider, Columbus; Public Relations, Mrs. Farrell Gallagher, Lakewood; Historian, Mrs. Fred Brosius, Middletown.

Chairmen of Special Committees: Bulletin and Handbook, Mrs. Harvey J. Staton, West Carrollton; Credits and Awards, Mrs. Karl Ritter, Lima; Radio and Visual Education, Mrs. Ross Knoble, Sandusky; Nurses' Scholarship Loan Fund, Mrs. D. H. Downey, Dover; Honorary Member, Mrs. John L. Stevens, Mansfield; Constitution and Archives, Mrs. J. Edwin Purdy, Canton; Convention Chairmen, Mrs. Farrell Gallagher, Lakewood, and Mrs. D. M. Keating, Cleveland; Editorial Staff, Medical Auxiliary News—Mrs. S. L. Meltzer, Portsmouth, Editor, Mrs. Gerald H. Castle, Cincinnati, Mrs. George Cooperrider, Columbus, Mrs. Clyde M. Fitch, Portsmouth.

Mrs. John L. Stevens, past-president and honorary member, installed the officers. The convention adjourned after Mrs. C. W. Kirkland gave an inspiring inaugural address and introduced the members of the new Board. The courtesy resolutions were given by Mrs. Azel Ames.

LUNCHEON FOR THE NEW PRESIDENT

A luncheon honoring the new president, Mrs. Kirkland, and her officers, was held Thursday noon. Dr. D. M. Creamer, president of the Belmont County Medical Society, was introduced. The guest speaker was Mrs. Luther D. Kice of New York, National President of the Woman's Auxiliary. "We cannot tax our way to good health," she pointed out, and she urged every auxiliary to "mobilize" its forces, in the crucial issue at stake.

A Post-Convention Board meeting followed the luncheon. The registration for the convention was 262.

Use of Beryllium in Lights To Be Discontinued

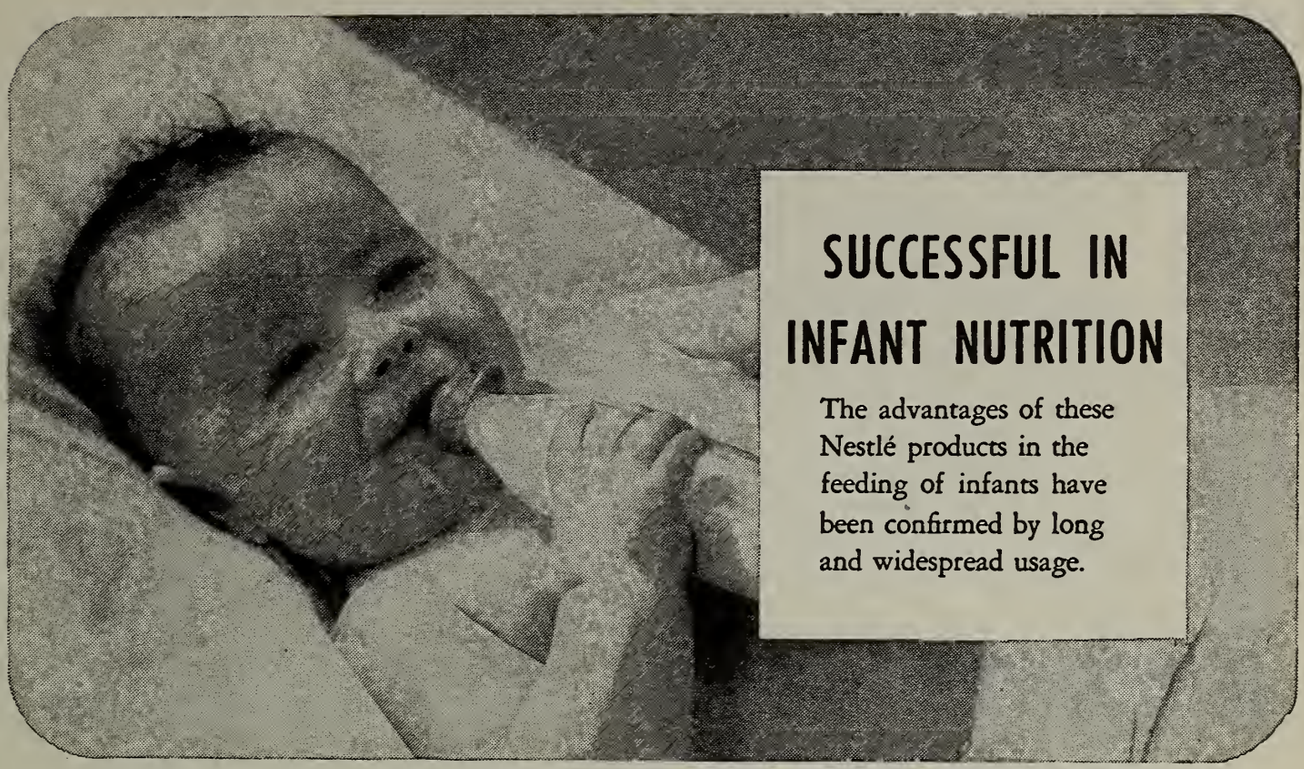
After consultation with officials of the Public Health Service, major manufacturers of fluorescent lights have stated that after June 30 they will no longer use beryllium phosphor in the manufacture of fluorescent lights, according to Dr. Leonard A. Scheele, surgeon general of the P. H. S.

The medical advisory committee to the industry reported that there had been cases in which cuts on persons from broken old lights healed slowly. Such cuts do not cause any general sickness or spread further on the body, it contended.

There is no record of any person suffering injury from breathing dust from an occasional breakage of a lamp, the report further stated. Precautionary measures should be taken to protect persons engaged in breaking large numbers of fluorescent lamps, the committee advised.

Ohio State Alumni Dinner

The Medical College Alumni of Ohio State University has scheduled a dinner to be held Wednesday, June 8, at the Marlborough Blendheim Hotel, Atlantic City, N. J., during the Annual Session of the American Medical Association, Dr. Russel G. Means, announced. Alumni, faculty and friends are invited.



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Requests for literature on any of these products will be given prompt attention.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

TIME TO STAND UP AND BE COUNTED

Refusing to recognize prevailing signs and trends, there are still some physicians who cling to the belief that the medical profession as a group and through its organizations should keep its hands out of politics. If they have in mind "party politics" as such, they have an argument. If they mean "politics" in its broader sense, namely an interest in governmental affairs and policies, electing qualified men to office, exerting influence for or against the enactment of legislative proposals, then they are all wet.

Dr. George F. Lull, general manager of the American Medical Association, hit the nail on the head in the following statement in answer to the question as to whether a scientific group should "get mixed up in politics":

"The answer to that question is that we are 'mixed up in politics' whether we like it or not, because medicine has been brought under political attack.

"The only question which remains is whether we are going to defend our profession against that political attack—and how we can do it most effectively.

"If Compulsory Health Insurance is enacted, every medical organization will be subject to political controls and influence—and every doctor will be restricted in the practice of his profession. Then we really will be 'mixed up in politics!'

"That issue, we believe, makes it imperative that all medical organizations—scientific or otherwise—take their stand, publicly and vigorously, against the emasculation of sound medical practice.

"American medicine needs to present a united front against politically-controlled medical practice—and we believe it is not only ethical, but highly desirable for our scientific groups to make their position known.

"Let's stand up and be counted!"

ACCORDING TO MR. YOUNG IT'S VERY, VERY SIMPLE

Ohio's Congressman-at-Large, Stephen M. Young, Cleveland, writes a column for *The Labor Union*. In the April 29 issue of that newspaper, Mr. Young offered the following, not too enlightening, comment:

"Regarding socialized medicine there seems to be more heat than light. The bill most talked about in the congress actually does not provide socialized medicine. It simply purposes imposing a small contributory tax about the same way as social security taxes are imposed. Funds so collected would be returned to the states which institute group medical plans.

"Medical men in any given area would be free to participate or not, just as they wish. Individuals would be free to choose their doctors within the group or to ignore the plan completely. There is no socialization involved. Uncle Sam simply serves as a collecting agency, allowing states to do the actual administering. No doctor would be an employee of our government."

It sounds very, very simple the way Mr. Young puts it. We're inclined to believe that he either had his tongue in his cheek when he wrote the above or is totally ignorant of the implications of the bill discussed. If the first is true, he is guilty of scattering erroneous information. If he hasn't learned by this time what socialized medicine really is, he had better start getting wised up. A lot of people in Ohio are going to demand a better statement from Mr. Young than the above in the fall of 1950 when he probably will stand for reelection.

RIGHT APPROACH TO A REAL PROBLEM

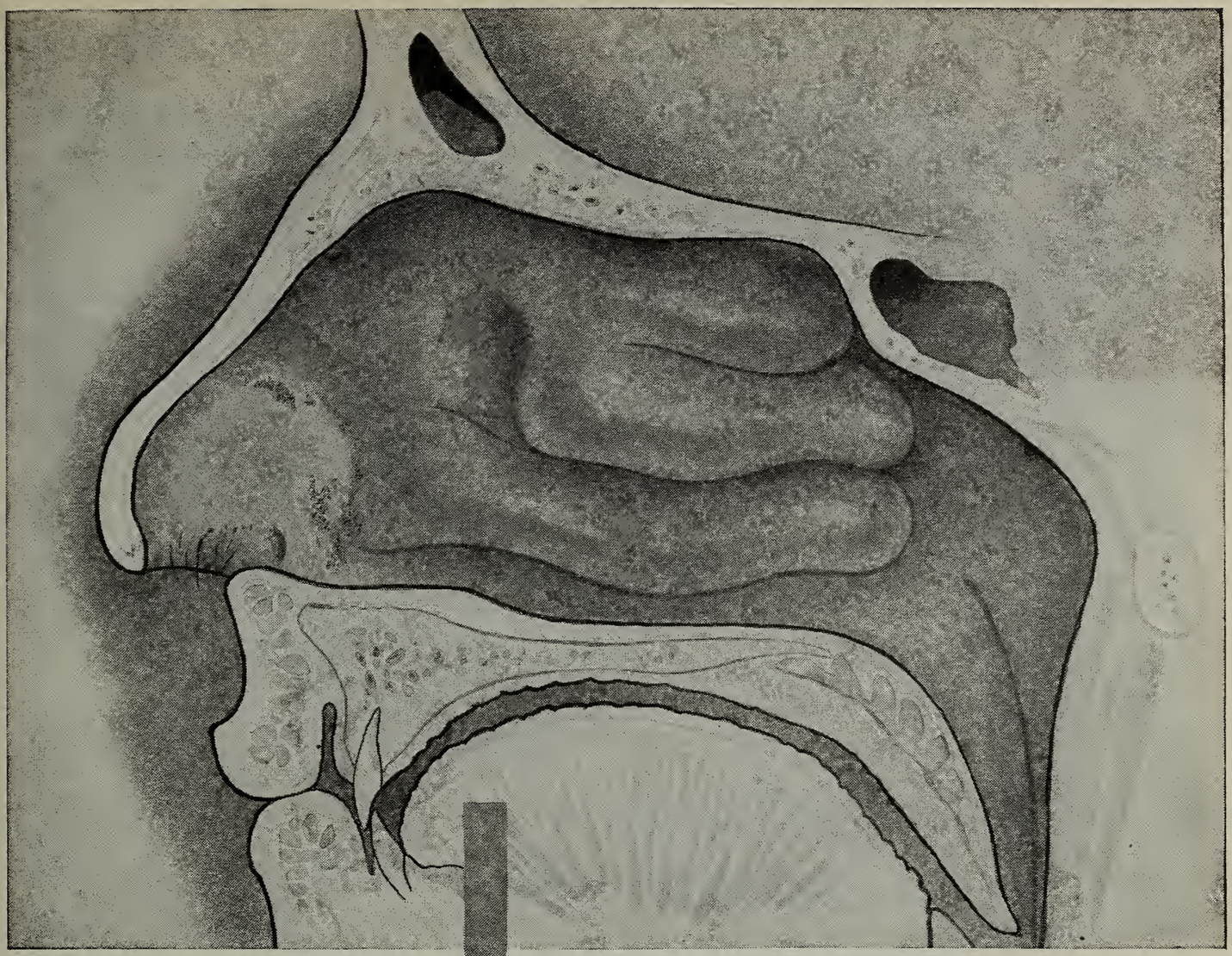
Eighty-four physicians of Summit County, mostly general practitioners, have signed up to participate in the Summit County Medical Society's rotational roster plan through which the public can obtain medical services in emergencies or on their own physician's day off. Each doctor is on second call for one 24-hour period and then he goes on first call for the following 24-hour period. Thus, one man is on call for two consecutive days every 84 days. The central Doctors' Telephone Exchange is used as a clearing house. The service is available only if a person's own doctor cannot be reached.

This plan, which should be put into force in every community, is designed to meet repeated criticism on the part of the public. It has met with favorable comment from the public and the press. Commenting on it, the *Akron Beacon Journal* said:

"Summit county physicians have inaugurated a new service aimed at counteracting one of the most common criticisms directed at medical practitioners. No longer will patients be able to complain that they were unable to get medical attention when it was most urgently needed.

"This inability to find a doctor—at night and on Wednesday afternoons especially—has been the basis for loudest complaints and most vociferous support of socialized medicine. Summit county physicians are wise to present such a program to eliminate it.

"If doctors all over the country would show



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activity in
COLDS
SINUSITIS
HAY FEVER

Ciliary motion carries away exudative debris in the upper respiratory passages. This action should not be inhibited by therapy of the common cold, sinusitis or hay fever.

The isotonic solutions of Neo-Synephrine hydrochloride permit ciliary function to continue in an efficient manner, while congestion is reduced by vasoconstriction.

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Supplied in ¼% solution (plain and aromatic), 1 oz. bottles. Also, 1% solution (when greater concentration is required), 1 oz. bottles, and ½% water soluble jelly, ⅝ oz.

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similar awareness of patients' difficulties and would act to solve them, the clamor for Federal invasion of the medical field would be lessened appreciably."

More actions like this throughout Ohio will be the best weapons which can be used against the Truman socialization plan as they prove that the medical profession is taking positive steps itself to meet the public's problems.

CLUB WOMEN VOTE "NO" ON COMPULSORY HEALTH BILL

Ohio can be proud of the fact that its own Ohio Federation of Women's Clubs at its 1949 annual meeting, adopted a strongly-worded resolution opposing compulsory health insurance on the eve of the General Federation of Women's Clubs annual session in Hollywood, Florida, at which a similar resolution was adopted.

Special commendation should go to this great organization for its courageous and correct stand on this issue.

Other similar organizations should be encouraged to take prompt action protesting the Truman program. Many of them will do so if properly contacted and provided with basic information. It's the job of the local medical societies and the local medical society auxiliaries to see that this happens.

LESSONS FROM ERRORS OF BRITISH PROFESSION

Addressing the West London-Medico Chirurgical Society February 18, on the subject "Whither Medicine?," Lord Horder of London, chairman of Britain's Fellowship for Freedom in Medicine, commented on the profession's mistakes of the past in connection with the Socialized Medical program in England.

He declared: "We physicians must lead; we must guide the politicians, since they cannot act without expert help; we must keep the citizen's end up, since he learns to rely upon us for support." He then pointed out that when the politician won't be guided, "the physician has no alternative but to appeal to public opinion, continuing to serve his patient in the best manner which he believes to be in the patient's best interest."

Lord Horder apparently believes that a good case could have been made before the public for a constructive program but that the mechanism was lacking. He stated it this way, ". . . We failed to get support. So, scattered in different camps, we were taken off our feet. Precipitate action was the order of the day . . . Many of us were bustled into this premature action against our better judgment. . . . We should have emphasized our belief that gradual extension and improvement of medical care is preferable to revolutionary changes and that, while recognizing Government responsibility for citizen's health, sweeping legislative action would defeat its own purpose by impairing the spirit and quality of a service which is essentially individual and personal."

In our opinion, we can take a lesson from the failure of the English profession to get behind its own program, to take its case to the public, and to fight for it in a unified manner.

We have a fine program to offer . . . the A. M. A. 12-point program; we have the mechanism to tell our story to the public in the A. M. A. National Education Campaign, and our own state campaign; and we have the unity provided by the strength of the American Medical Association. It remains for every member to get into the fight.

GIVE ME A NICKEL'S WORTH OF YOUR BEST NEWS, PLEASE

"U. S. newspaper circulations, daily and Sundays, not only maintained their all-time high levels, but actually showed small gains in 1948 as compared with 1947." So states *Editor & Publisher.*

Articles without end could be written about the good, bad or indifferent impressions the public press is making on the minds of the public; but the record high circulation figures show one thing conclusively—the public wants to know what is going on or perhaps what is being said about what is going on.

People want to know what is going on in the medical profession. They want to know how they can get the best medical care for their money. It is better that they get their information from the medical profession through information supplied by medical societies or by physicians in talks before public gatherings—not from some politician who has one foot on the moon and the other on a ballot box.

PITY POOR, PATHETIC LITTLE OLD OHIO (?)

Add "Do You Know": Compared to the national average of 50.4 cents per capita, Ohio budgeted 9.9 cents per capita for public health during 1948; the state appropriation provided for about 4.5 cents per capita for subsidy to local public health services and 5.5 cents per capita for operation of the Ohio Department of Health; the state appropriation placed Ohio 47th in the list of states in the matter of state expenditures for public health services.

If your guess is that a large proportion of the money spent in Ohio for public health services came as grants from the Federal Government, you can go to the head of the class.

How long is this situation going to be tolerated?



Further evidence of the safety of 'Benzedrine' Sulfate therapy

More data, showing that 'Benzedrine' Sulfate, in proper dosage, produced no toxic effects, have lately been published in a study by Caveness.[1]

He gave the drug for 14 consecutive weeks to 23 unselected hospital patients whose ages *averaged 65 years.* Daily dosages over the period ranged from 5 to 30 mg. The author observes:

"... no significant changes were noted in the cardiovascular, urinary, hematopoietic, or respiratory systems..."

From this study, it would appear that 'Benzedrine' Sulfate may be safely used in the treatment of depression in the aged.

1. New York State J. Med. 47:1003

Benzedrine* Sulfate tablets • elixir

(racemic amphetamine sulfate, S.K.F.)

*T.M. Reg. U.S. Pat. Off.

one of the fundamental drugs in medicine

Smith, Kline & French Laboratories, Philadelphia

Narcotic License Must Be Renewed By July 1 To Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, re-register with the Collector of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of $1.00. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

PENALTIES

Failure to re-register within the time allowed by law adds a penalty of 25 per cent to the annual tax, and in addition makes the physician liable to a fine not exceeding $2,000 or to imprisonment for not more than five years or both. In recent years the Commissioner of Internal Revenue has given some tardy registrants the choice between paying sums by way of compromise in lieu of the penalties for their offenses, or as an alternative, accepting criminal prosecution, with resultant publicity and liability to fines and possible imprisonment. Strict adherence to the law will obviate the necessity for such action and protect the physician from needless embarrassment.

FORMS MAILED

Copies of the forms for re-registration are mailed by the District Collectors of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed.

Application for re-registration must be made on Form 678, signed by the physician applying and either acknowledged by two qualified witnesses or sworn to by a Notary Public or an official of the Internal Revenue Department. The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. **Remittance accompanying the application may be in the form of cash, a postal money order, or certified check. Personal checks not certified, will be returned to the sender.**

INVENTORY NECESSARY

An inventory of the narcotic drugs on hand in the physician's office must accompany the application, on Form 713. The regulations require that this inventory must be sworn to by a Notary Public or an official of the Internal Revenue Department regardless of the quantity of drugs on hand.

Inventories may be taken at any time after the receipt of the application forms each year, and may be filed as soon as completed. They must be filed by July 1.

Physicians who administer, dispense, or prescribe cannabis, must obtain a special permit under the Marihuana Tax Act, and re-register annually on or before July 1, with the Collector of Internal Revenue of his district, and pay a tax of $1.00.

MUST APPLY AFTER MILITARY SERVICE

A physician in the armed forces need not re-register. If such a physician should receive an application form for re-registration he should return it to the office of the Collector of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

Upon his return to civilian practice, a physician who has been in military service must immediately apply for registration. He will be assigned his former registration number.

NEW ORDER FORM

A new type of official narcotic order form, for physicians who order narcotics from supply houses, is now being furnished upon request. The new form is Form 679. Registrants, however, may continue to use the 1936 series until their present supply is exhausted or until the old forms are invalidated.

'Misbranding' Case Decided

The U. S. Supreme Court recently decided the Kordel and Urbuteit cases in favor of the Federal Government, thereby providing a strong deterrent to interstate marketing of misbranded "health foods" and therapeutic devices.

Involving the same issue—whether labeling literature must be affixed to or physically accompany the product to bring the shipment within the purview of the Federal Food and Drug Act—the two cases were heard together. "It would, indeed, create an obviously wide loophole to hold that these drugs would be misbranded if the literature had been shipped in the same container but not misbranded if the literature left in the next or in the preceding mail," said the majority opinion. "No physical attachment one to the other is necessary. It is the textual relationship that is significant."

Underwriters Boost Heart Research

Life insurance companies of the United States and Canada will contribute $680,000 during the coming year for the support of heart disease research, it was announced recently. The awards raise to more than $2,500,000 the amount contributed by the companies since the Fund was started late in 1945.

Three grants amounting to $34,125 were made to Western Reserve University School of Medicine.

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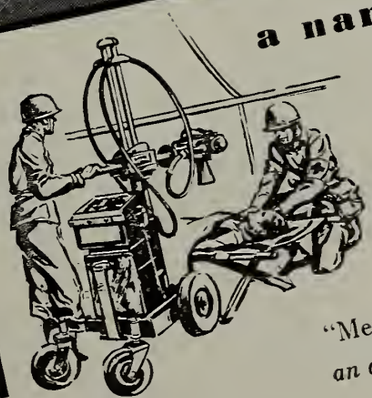
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Do You Know? . . .

Blue Cross members in the Cincinnati area were hospitalized for an average stay of only 6.2 days during 1948, considerably less than the national average of 7.41 days.

* * *

Copies of the 12-point program of the American Medical Association for the advancement of medicine and public health can be obtained by writing the State Headquarters Office of the Ohio State Medical Association, 79 E. State St., Columbus 15.

* * *

Governor Warren again is sponsoring a compulsory state health insurance bill in the current session of the California legislature. A similar bill was barely defeated at the session two years ago.

* * *

Dr. E. Perry McCullagh, Cleveland, was one of the guest speakers at the postgraduate assembly of The Association for the Study of Internal Secretions held recently at Oklahoma City.

* * *

Dr. David A. Chambers, president of the Cleveland Academy of Medicine, recently addressed the senior students at Western Reserve University School of Medicine on "Medical Organizations and the American Medical Association's Educational Program."

* * *

Delegates to the annual convention of the General Federation of Women's Clubs, which has a membership of five million in the United States, meeting in Hollywood, Florida, April 28, adopted unanimously a resolution which opposed "Government control of health services" and supported "the extension and development of Voluntary Health Insurance." Similar action was taken by the Ohio Federation of Women's Clubs at Toledo, April 7.

* * *

Denison University has announced the establishment of a memorial prize of $100 for the senior premedical student showing the greatest aptitude. Dr. Wynne M. Silbernagel, Columbus, Denison alumnus, and his mother made the gift as an annual award in memory of his father, the late Dr. Charles Edward Silbernagel.

* * *

The first assignment by the Ohio State Medical Association's new State Public Relations Speakers Bureau went to Dr. Thomas E. Rardin, Columbus, who spoke to the Marion Kiwanis Club on "Medical Perspective of Federalized Medicine."

"What's New on the Legislative Front?" was the subject of a talk made by George H. Saville, director of public relations, Ohio State Medical Association, May 11, at a joint meeting of the Franklin County chapter of the Ohio Academy of General Practice and the Medical Section of Grant Hospital in Columbus. He also recently addressed a class of graduate students in the School of Social Administration, Ohio State University, Medical Forum, Pilot Club, Mercator Club, all of Columbus, and a joint meeting of the Lake County Medical Society and the Women's Auxiliary at Willoughby.

* * *

Charles S. Nelson, Executive Secretary, Ohio State Medical Association, spoke on "Medical Organization" at a recent meeting of the Sophomore Class of the Ohio State University College of Medicine.

* * *

Dr. H. B. Wright, a member of the Board of Directors of the Cleveland Academy of Medicine and chairman of a special committee which has been cooperating with the Cleveland Better Business Bureau in a joint effort to curb illegal and unethical practices in activities allied to medicine, has been chosen a member of the Board of Directors of the Better Business Bureau. Dr. Wright presented the viewpoint of the medical profession in a forum on "Socialized Medicine" at Oberlin College, Oberlin, May 23.

* * *

The following Ohio physicians have been named members of a national advisory beryllium committee to the U. S. Atomic Energy Commission: Dr. Morris G. Carmody, Painesville; Dr. H. S. Van Ordstrand, Cleveland; and Dr. J. M. DeNardi, Lorain.

* * *

A West Virginia physician is seeking Congressional support of a limited liability medical insurance plan, whereby a family would be protected from overwhelming expenses imposed by protracted illness or serious injury.

* * *

Dr. Russell B. Crawford, Lakewood, was voted president-elect of the Ohio Hospital Association, at a meeting held in Columbus on March 25. He will succeed Miss Neil Robinson, superintendent of East Liverpool City Hospital, in March, 1950.

* * *

Dr. L. Howard Schriver, Cincinnati, was a guest speaker at the Annual Meeting of the California Medical Association which was held in Los Angeles May 8-11.

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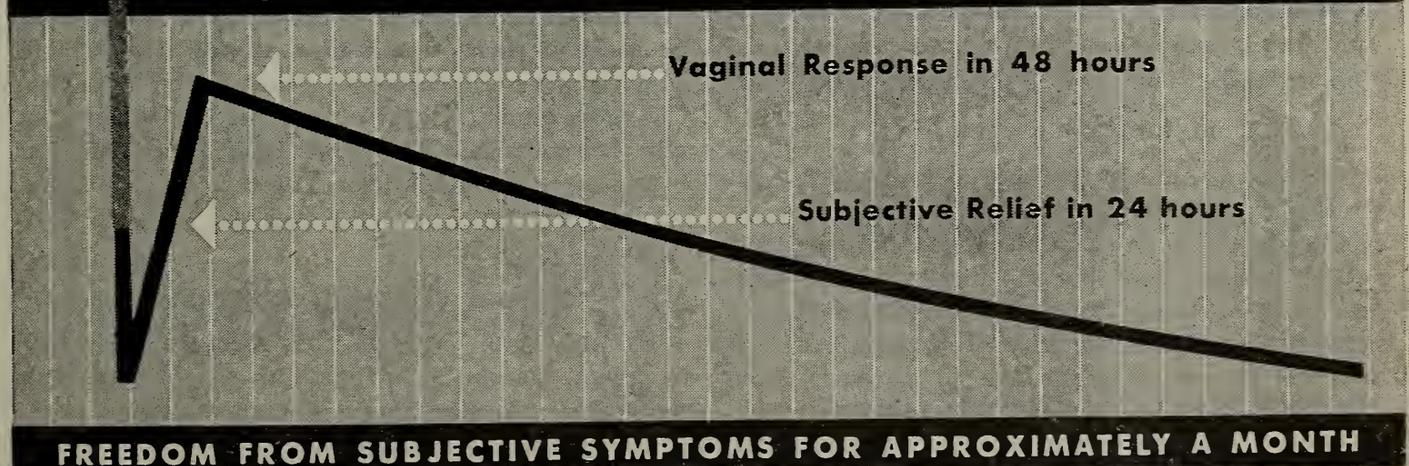
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More on British National Insurance . . .

English Doctor on Tour in This Country Gives Interesting Sidelights On Socialized Medical Plan in the Isles and Some of Its Shortcomings

THE following article gives additional first-hand information on the socialized medical program as practiced in Great Britain, and will be of interest to many physicians in this country who live under the threat of a metastasis of the plan to the United States.

The information contained in the article was extracted from informal talks given by Dr. L. P. Garrod, professor of bacteriology at the University of London, England, who took part in the 22nd annual spring graduate course given at the Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va., and was reported to *The Journal* by Dr. Leo D. Covert of Bellaire. Dr. Garrod at the time was giving a series of lectures on the use of penicillin and streptomycin while on tour in this country.

* * *

Under the British system of socialized medicine, the private practitioner is paid a given sum for each patient on his list. The limit for any one physician's panel is 4,000 patients—a number which gives him a very good income. No conscientious physician, however, can take care of that many patients in the way he would like, nor can he give worthy ones treatments they deserve. The physician who is conscientious, therefore, cannot possibly take care of that number, and probably will have to limit his number to near 1,000. This limit gives him a very inadequate income.

Of course, after the government has paid him his fees which will be only an average income, it immediately takes back more than half of it in income taxes.

LINE UP TO SEE DOCTOR

Patients queue up for the doctor's office just as they have been accustomed to do for almost everything else in England for the last few years. There may be so many at his office that it is humanly impossible for the doctor to take care of them properly. He, therefore, will have to try to sort out the ill patients from those who may be termed "complainers."

One of the abuses of the system is that, because of the number of patients in the doctor's office, someone may call from his home and state that he has a high temperature and demand that the doctor "come at once."

The cost of the system has become outrageous because there is no limit to requests for all sorts of services and appliances. Before the system was established, officials estimated that it would cost 114,000,000 pounds per year. Actually the cost is running about 500,000,000 pounds. The assessment to the people was set up on an estimate from the first figure, which means that about two-and-a-half times the initial estimate must be paid for out of general taxes. The people will not appreciate it when they realize that approximately three-fourths of the cost of the program is coming from sources other than their assessments.

GOVERNMENT PRESCRIBING TREATMENTS

Physicians and hospitals were assured that they would remain independent, but in actual practice the hospitals already are losing control of their own medical staffs while this control is being taken over by the government. The government, after only one year of regimentation, is beginning to issue directives on how illnesses shall be treated by physicians. Salaries of all hospital personnel, both professional and lay workers, are fixed by the government. Professors themselves are getting very low salaries.

The system apparently is welcomed by the poor, but is not needed by the wealthy. Dr. Garrod stated that at least 95 per cent of the medical profession is opposed to the plan after having tried it for this period of time. Already the government is publishing lists of towns where no more physicians will be permitted to practice. The government also is taking over training of medical students—that is, it is subsidizing medical students. All able bodied young men must choose a branch of military service, after which they can be educated at government expense. The government, therefore, picks out boys who will be permitted to go to medical school. A boy who can pay his own way has no assurance whatsoever that he will ever be able to get into medical school.

GREATEST COST IS ADMINISTRATION

Of the total cost of the socialized medical program, roughly one-fourth is paid to medical personnel. A very large amount of the cost is for administration, members of which give no benefit whatsoever to the individual patient. Medical men are stampeding to become specialists, because as such they get a much better financial return. Specialists have appointments in hospitals and are paid according to the number of patients they see. They also are are used as consultants, a service which gives



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them extra income. These men also may have some private practice, although private practice is not permitted to men who have panels. Dr. Garrod stated that seven years ago when he took his Board there were 12 men taking it with him. Now about 500 apply in a year for the same Board.

Paper work is "appalling." Doctors have to spend much more time on certificates and reports than in actual medical care, but they have to do this in order to keep out of all sorts of trouble both with the patients and the government.

REFRESHER COURSES RARE

There is an attempt being made to give some postgraduate work to medical men without cost to them. Dr. Garrod stated, however, that it would be impossible in England to give such a course as the one in which he was taking part in Roanoke. He stated that he did not believe many patients are leaving the panels to consult private practitioners. Some are assuring themselves better than average care in many cases by giving a so-called "cash" payment to their doctors. This practice is as strictly illegal as it is unethetical and any such income cannot be reported for income tax purposes.

As regards the present labor government in England, Dr. Garrod does not think there will be any change reasonably soon. That observation was expressed in spite of the fact that almost everyone who comments apparently is against the plan, but there are too many voters who still think they are getting something for nothing by the "soak the rich" principle of taxation.

When asked how the non-working indigent was taken care of under the system, Dr. Garrod said that he did not know and that as far as he knew there is nothing in the system which takes care of the man who is not paying his weekly sum to the government.

Cancer Film Available

A new film, titled "Cancer: The Problem of Early Diagnosis," which has received the approval of the American Medical Association's Committee on Medical Motion Pictures, was made available to the medical profession recently through more than 50 state and regional distributing points.

Co-sponsors are the American Cancer Society and the National Cancer Institute of the U. S. Public Health Service. Prints for single showings may be borrowed by medical societies and other professional groups from the Ohio Division of the American Cancer Society or the Cancer Division of the Ohio Department of Health.

Ft. Steuben Doctors Meet

The May meeting of the Fort Steuben Academy of Medicine was held on May 10 at the Fort Steuben Hotel. Dr. Phillip Thorek, University of Illinois College of Medicine, was guest speaker and talked on "Acute Intestinal Obstruction." The discussion was opened by Dr. John W. Shirer of the University of Pittsburgh. Dr. C. W. Lighthizer led the floor discussion.

Hamilton Doctors Give Program

The second clinical program of the Hamilton Academy of Medicine was held at Mercy Hospital in Hamilton on April 3. Dr. Arnold Iglauer, and Dr. Virgil D. Hauenstein of University of Cincinnati College of Medicine, spoke on "Pathologic Physiology of Congestive Heart Failure," and "Application of Physiologic Principles to the Treatment of Congestive Heart Failure," respectively.

O. S. U. Group Meets

Among doctors who attended the Ohio State University College of Medicine Class of 1914 in Columbus during the Annual Meeting were the following: Drs. C. F. Wharton of Akron, S. D. Edelman, N. A. Albanese, J. E. Kerschner, Wayne Brehm, all of Columbus, R. F. Jolley of Akron, W. T. Fenker of Sandusky, W. H. Curtiss of Dennison, M. D. Soash of Bluffton, H. L. Basinger of Lima and R. C. Mauger of Newark. Others also were present.

Class of '09 Meets

Members of the old Starling Ohio Medical College's class of 1909 met in reunion during the Annual Meeting in Columbus. Those present included: Drs. W. H. Morgan and John R. McClure of Newark, A. J. Pearse, Cleveland, Fred Brosius of Middletown, J. H. Frame of Wilmington, A. N. Vandeman of Spring Valley, V. L. Magers of Tiffin, E. A. Jones of Youngstown, A. N. Smith of Toledo, L. R. Courtright of Dayton, Alfred D. Potter of Springfield, and Glen G. Edwards of Willard. Other members also were present.

Opinion of Attorney General

Syllabus of Opinion No. 290 of Attorney General Herbert S. Duffy, is as follows: "County commissioners are not authorized to pay the fees of county coroner which accrued in prior years, where such fees are governed by Secs. 2856 to 2866-1a, G. C., when an appropriation had been made by such commissioners for such coroner in each prior year, but by reason of the coroner's failure to file his cost bills in such prior years each prior appropriation had reverted to the general fund and had subsequently been reappropriated and expended or encumbered for other purposes."

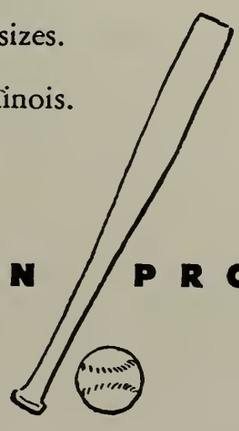


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In Memoriam . . .

George C. Clisby, M. D., Kinsman; Western Reserve University School of Medicine, 1900; aged 76; died April 19; former member of the Ohio State Medical Association and the American Medical Association through 1931. Dr. Clisby practiced in Kinsman from 1900 to 1946 when he was forced by his health to retire. He was a member of the Congregational and Presbyterian Church and the Masonic Lodge. Surviving are two sons.

Hugh W. Chaney, M. D., Sugartree Ridge; Hospital College of Medicine, Louisville, Ky., 1903; aged 78; died May 3; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1948; president of the Highland County Medical Society in 1921; vice-president in 1923 and 1934; delegate to the Ohio State Medical Association 1929 through 1933 and 1935 through 1947. Dr. Chaney practiced medicine in the Sugartree Ridge vicinity for approximately 45 years.

Jesse F. Conrad, M. D., Magnetic Springs; Eclectic Medical College, Cincinnati, 1901; aged 76; died April 20. Dr. Conrad began practice in Union County 48 years ago and in 1926 began operation of the hotel and health resort at Magnetic Springs. He was prominent in civic and political activities of his community. Surviving are his widow, one son, four brothers and two sisters.

Floyd Harrison Cook, M. D., Akron; Syracuse University College of Medicine, 1907; aged 68; died April 12; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947. Dr. Cook went to Akron from New York City 28 years ago and established practice there. In addition to his private practice he was surgeon for the Erie Railroad. He held membership in a number of organizations including the Akron City Club and Phi Beta Pi medical fraternity. Surviving are his widow, one son, one daughter and one brother.

William Lewis Ely, M. D., Fredericktown; Cleveland Medical College, Homeopathic, 1893; aged 83; died April 30. Dr. Ely began practice in Fredericktown in 1893 and continued until his retirement only recently. He was a member of the Masonic Lodge. Surviving are his widow and a stepdaughter.

Whitaker R. Hill, M. D., Toledo; University of Louisville School of Medicine, 1925; aged 52; died April 13 by accidental drowning while in Florida; member of the Ohio State Medical Association and the American Medical Association. Dr. Hill began his practice in Toledo immediately after completing his medical education. He held membership in several Masonic orders. Surviving are his widow, three sons, a daughter and a brother.

Herman Hendrix McConkey, M. D., Canton; Jefferson Medical College of Philadelphia, 1934; aged 39; died April 14; member of the Ohio State Medical Association and the American Medical Association. Dr. McConkey 13 years ago went to Canton where, in addition to his private practice, he was physician for the Republic Steel Corporation. During World War II Dr. McConkey served with the Army Medical Corps in the Pacific theater. In addition to professional organizations, he held memberships in Phi Kappa Psi, Beta Beta Beta and Theta Chi Delta fraternities. Surviving are his widow, two daughters, his mother and a brother.

John Gilbert McDougal, M. D., New Lexington; Medical College of Ohio, Cincinnati, 1882; aged 89; died April 27; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Perry County Medical Society in 1934; delegate to the Association, 1920, 1932 and 1933. Dr. McDougal began his practice in New Lexington immediately after completing his medical education and, in spite of his age, continued practice until shortly before his death. He was a member of the Elks Lodge, several Masonic Orders and was a director of the Perry County Bank. Surviving are his widow with whom he celebrated his 64th wedding anniversary recently and two sons, including Dr. Charles B. McDougal, also of New Lexington.

Dudley White Palmer, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1906; aged 72; died April 23; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Surgery; member of the American Surgical Association and the American College of Surgeons; president of the Academy of Medicine of Cincinnati in 1929. After a period at Rochester, Minn., Dr. Palmer returned to Cincinnati and established his practice there. In 1935 ill health forced him to go into semi-retirement and later into full retirement. He was a member of the Cincinnati Country Club, University Club, Beta Theta Pi and Nu Sigma Nu. Surviving are a son and a daughter.

Rudolph Robert Remark, M. D., Sinking Spring; Eclectic Medical College, Cincinnati, 1920; aged 70; died April 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Remark began practice in Cin-

cinnati in 1933. He was a member of the Methodist Church and the Masonic Lodge. During World War I, Dr. Remark served in the Army Medical Corps. Surviving are his widow, a son, a daughter and two sisters.

James Richard Tillotson, M. D., Lima; Medical College of Ohio, Cincinnati, 1904; aged 72; died April 20; member of the Ohio State Medical Association; Fellow of the American Medical Association; diplomate of the American Board of Orthopedic Surgery; member of the Clinical Orthopedic Society and the American College of Surgeons; president of the Allen County Medical Society in 1928; vice-president in 1925; secretary in 1921; treasurer in 1943 and 1944; delegate to the Association, 1938-39 and 1941-42; legislative committee chairman, 1924-25. Dr. Tillotson began his medical career in Delphos and left there to go into military service during World War I. He continued at Walter Reed General Hospital for several years before moving to Lima in 1921. He was a member of several Masonic orders and of the Rotary Club. Surviving are his widow, a son, Dr. John F. Tillotson of Rochester, Minn., and a daughter.

J. Cliff Wetherill, M. D., Weston; Ohio State University College of Medicine, 1909; aged 65; died May 3; member of the Ohio State Medical Association and the American Medical Association; Dr. Wetherill practiced his profession in Weston for approximately 40 years. A veteran of World War I, he was vice-president of the Weston Citizens Banking Company, was a member of Masonic bodies and was active in Republican committee work. Surviving are his widow, a son and a stepsister.

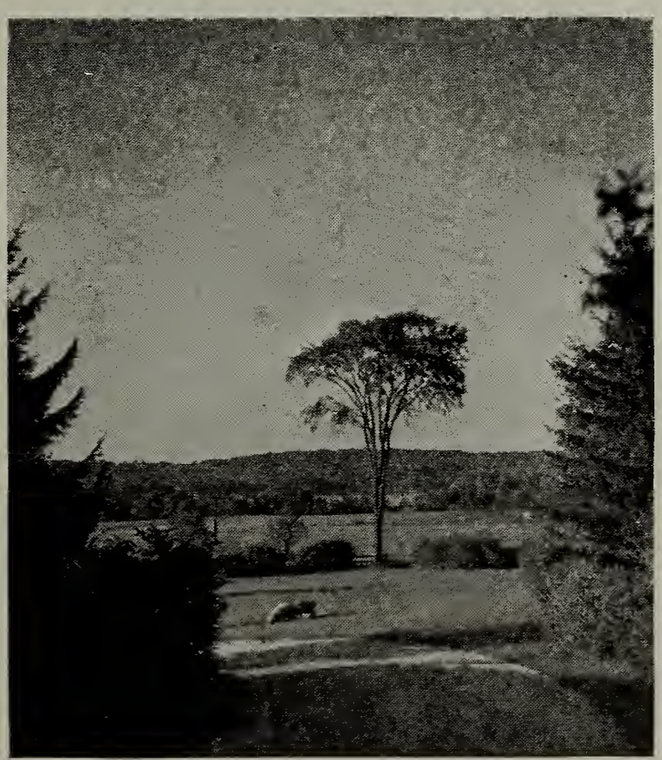
Emil Edward Wolf, M. D., Orlando, Fla.; Western Reserve University School of Medicine, 1916; aged 58; died April 21; former member of the Ohio State Medical Association and the American Medical Association through 1933. Dr. Wolf practiced in Cleveland before his retirement about 10 years ago. Surviving are his widow, a son, two daughters and two sisters.

Urology Course Scheduled for Chicago in December

The first postgraduate course in urology to be sponsored by the North Central Section of the American Urological Association will be held at the Hotel Sherman, Chicago, December 5-9. In addition to members of the section, residents in urology and physicians interested are invited. Tuition fee will be $50. Attendance will be limited. Applications and requests for information should be addressed to Dr. William J. Baker, 7 W. Madison St., Chicago 2.

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Buckeye News Notes . . .

Ada—Dr. Robert A. Thomas spoke on "Socialized Medicine" at a meeting of the Rotary Club.

Akron—Dr. A. S. McCormick is distributing among his friends printed copies of three poems of which he is the author. They are entitled "The Doctor's Life," "The Student Nurse's Life" and "The Fire Horses."

Bellaire—Dr. Burrell Russell, New Philadelphia, addressed the Bellaire Kiwanis Club on the subject of socialized medicine.

Chillicothe—Dr. C. D. Leggett received the title of "Golden rule honor citizen" during May at the Junior Chamber of Commerce program "The Best Is Yet To Come."

Cincinnati—Dr. M. A. Blankenhorn was principal speaker at annual meeting of the Children's Heart Association.

Cincinnati—The Cincinnati Medical Women's Club and Branch II of the American Medical Women's Association, under the chairmanship of Dr. Dora F. Sonnenday, entertained women physicians who attended the Annual Assembly of the American Academy of General Practice. Forty women physicians enjoyed the hospitality.

Circleville—Dr. A. D. Blackburn was installed as exalted ruler of the local Elks Lodge.

Columbus—Dr. William F. Bradley has been named medical director of the Franklin County Home Hospital.

Columbus—Dr. Peter A. Volpe, formerly chief medical officer for Area 6 of the Veterans Administration, has moved to Dwight, Ill., where he is in charge of a Veterans Administration hospital.

Columbus—Dr. George M. Curtis received the 1949 Iodine Educational Bureau Award at a meeting of the American Pharmaceutical Association in Atlantic City early in May. Since joining the staff of Ohio State University College of Medicine in 1932, Dr. Curtis has written and published more than seventy articles concerning iodine metabolism and its associated problems.

Columbus—Dr. Joseph L. Morton, Ohio State University College of Medicine, spoke on "Research With Radioactive Cobalt" at a meeting of the Central Ohio Society of Medical Technologists.

Elmwood—Dr. Othilda Krug Brady of Cincinnati addressed a meeting of the P. T. A.

Elyria—Dr. Allan C. Barnes of Columbus addressed the Lorain County Planned Parenthood Association.

Elyria—Dr. Theodore Berg spoke on "Rheumatic Fever in Children" at a meeting of the Nurses' Alumnae of Elyria Memorial Hospital.

Hamilton—Five physicians took part in a panel discussion on "Socialized Medicine" at the Rotary Club. They were Drs. Ernest D. Davis, moderator, W. Fulton Hume, Howard M. Hunter, Paul C. Schumacher and William F. Smith.

Ironton—Dr. V. V. Smith addressed the local Lions Club on the subject, "Socialized Medicine."

Madison—At the age of 83, Dr. J. V. Winans was reelected to the Lake County Board of Health after serving on the board as president for 29 years.

McConnelsville—Dr. Deane H. Northrup of Marietta addressed the Malta-McConnelsville Rotary Club on the subject "Socialized Medicine."

Middletown—Dr. Edward A. Gall of Cincinnati gave an address on cancer at a "Town Meeting" sponsored by the local chapter of the American Cancer Society.

Painesville—Dr. Herbert B. Wright, Cleveland, addressed the local Kiwanis Club giving the viewpoint of the medical profession on socialized medicine.

Piqua—Dr. John T. Quirk, spoke before the Piqua Lions Club in the interest of the "Save a Heart" campaign.

Pomeroy—Dr. Raymond E. Boice was appointed to the board of directors of the Pomeroy National Bank.

Portsmouth—Dr. W. E. Obetz, Columbus, spoke in behalf of the Ohio Industrial Commission at a luncheon sponsored by the local Chamber of Commerce Safety Council.

Racine—Dr. John R. Philson was honored at a public reception in recognition of his having completed 52 years of practice.

Springfield—Dr. John B. Cooley was the subject of a recent feature article in the *Springfield Daily News.*

Toronto—Dr. H. D. McCulloch was honored by the local Kiwanis Club for his work as chairman of the Underprivileged Child Committee of that organization.

Troy—Dr. Melvin Oosting, of the Miami Valley Hospital in Dayton, addressed the Troy Kiwanis Club on the subject, "A Pathologist Looks at Cancer."

Vermilion—Dr. John Halley addressed the local Rotary Club on proposed plans to socialize medicine.

Youngstown—Dr. Harold J. Reese spoke over Station WFMJ in behalf of the cancer campaign.

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Roundup On Prepaid Medical Care Plans

Dr. Donald Cass, Los Angeles, a member of the Board of Trustees of California Physicians' Service, and Dr. J. F. Barker, Huntington, W. Va., a member of the governing board of Medical Care, Inc., were named members of the Blue Shield Commission at meetings held late in April at Hollywood, Florida.

Dr. Cass replaces Dr. C. L. Cooley, San Francisco, as a representative from District XI, while Dr. Barker replaces Dr. W. L. Powell, Roanoke, Va., as a representative from District V.

Dr. Walter F. Portteus, Franklin, Ind., and N. D. Helland, Tulsa, Okla., were reelected by the 1949 Annual Conference of Blue Shield Plans to represent the District XII, a district-at-large.

* * *

An invitation extended to Blue Shield Plans by Whitaker and Baxter to cooperate in the National Education Campaign of the American Medical Association was accepted unanimously by the Plans at their 1949 Annual Conference, meeting at Hollywood, Florida, April 18-20.

Whitaker and Baxter had offered assistance in the production of promotional materials for use by Blue Shield Plans in stepping up their enrollment. A working agreement was confirmed in April and the Blue Shield national office in Chicago has taken the initial steps toward getting into high gear production of exhibit displays, brochures, posters, films, and an extensive list of public relations and promotional materials.

A strongly worded resolution was adopted by the Blue Shield Plans, at their annual conference, in which they agreed to increase and expand their enrollment activities.

Materials to be produced by the Blue Shield national office will be made available at cost to sixty-two Blue Shield Plans, thereby passing on to each Plan the advantages of mass production and lower unit cost.

"In accepting this offer of assistance, Blue Shield is not only pledging itself to an all-out enrollment drive," stated Frank E. Smith, director of Associated Medical Care Plans, "but indicating its desire to cooperate with the objectives of the American Medical Association in extending low cost health protection as rapidly as possible to the American people."

* * *

Connecticut Medical Service, which was organized in January, 1949, and started enrolling subscribers in February, has signed more than 70,000 members during the first two months of enrollment effort. The first subscriber certificates became effective on April 1, 1949, with more than 70,000 members to be effective by June 1, 1949.

Equally phenomenal was the speed with which Connecticut physicians signed participating agreements with the new Plan after it had been incorporated. It was announced by the state society headquarters on May 1, 1949, that 86 per cent of the physicians, potentially available to subscribers, were participating in the Plan.

* * *

Ohio Medical Indemnity, Inc. (the Ohio Doctors' Plan), had contracts covering 516,758 individuals on April 30. Of that number, more than 16,758 persons were covered by new contracts added in April.

* * *

Reporting a net gain of better than 165,000 members during the first quarter of 1949, United Medical Service, New York, threatens to replace Michigan Medical Service as the largest Blue Shield Plan in the nation.

United Medical Service reached a total of 1,294,650 members on March 31, 1949, only a few thousand behind Michigan Medical Service with its 1,329,044 members as of the same date.

Although complete returns for the first quarter of 1949 have not been received by the Blue Shield national office, it is estimated that total membership in the non-profit Plans exceeded the 11,000,000 mark on March 31.

* * *

A silver plaque, commemorating the tenth anniversary of the founding of California Physicians' Service, was presented to Dr. Lowell S. Goin, president of the Plan, on May 8, during one of the sessions of the annual meeting of the California Medical Association.

Dr. L. Howard Schriver of Cincinnati, president, made the presentation in behalf of the Blue Shield Commission of Associated Medical Care Plans.

Engraved on the plaque was a recognition of the pioneer work of Blue Shield in California in providing prepaid medical care for the people of that state, together with an acknowledgment of the contribution made by C. P. S. to the national movement as a charter member of Associated Medical Care Plans.



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Licensed Through Endorsement By State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

January 25, 1949—Charles A. Barnes, Cleveland, Univ. of Chicago (Rush); Richard H. Bell, Cleveland, Northwestern Univ.; Charles L. Blumstein, Lima, Louisiana State Univ.; John E. Burnett, Jr., Springfield, Univ. of Mich.; Jack W. Cole, Cleveland, Washington Univ.; Robert C. Dunn, Columbus, Washington Univ.; Dorothy Eshbaugh, Columbus, Woman's Medical College of Philadelphia; Louis Halle, Columbus, Univ. of Louisville.

Willard T. Hill, Cleveland, Harvard Univ.; Quentin E. Howard, Cleveland, George Washington Univ.; Joseph H. Jones, Cincinnati, Univ. of Louisville; James I. Justice, East Liberty, Univ. of Maryland; Robert W. Kapp, Lakewood, McGill Univ.; Julian Kassewitz, Cleveland, Emory Univ.; Adolf Krakauer, Massillon, Leipzig; Richard P. Levy, Cleveland, Yale Univ.; Robert E. Logsdon, Marion, Univ. of Ill.; Theodore J. Lukens, Worthington, College of Medical Evangelists; Joseph J. McHugh, Ottawa, Jefferson Med. College; William A. Morningstar, Cleveland, Univ. of Pittsburgh.

Joseph T. Noe, East Liverpool, Univ. of Louisville; John D. Pattison, Jr., Toledo, Univ. of Pittsburgh; Paul Pipik, Cleveland, Univ. of Ill.; Frank W. Pisciotta, Columbus, Royal Univ. of Bologna; Paul Rosenthal, Dayton, Univ. of Berlin; Leon Ross, Cleveland, New York Univ.; Neb N. Rowihab, Elyria, Univ. of Louisville; Winsor C. Schmidt, Dayton, Howard Univ.; Edmund H. Schweitzer, Cincinnati, Northwestern Univ.; Frances J. Shaffer, Toronto, Univ. of Calif.; Alan E. Smith, Cleveland, Hahnemann Medical College; Morton H. Spinner, Bellevue, St. Louis Univ.; Anna Suliot, Salem, Univ. of Pittsburgh; Fred R. Tingwald, Youngstown, Univ. of Iowa.

April 19, 1949—Edward A. Abbey, Akron, Georgetown Univ.; Bernard S. Abrams, Cleveland, Indiana Univ.; Griffin M. Allen, Cleveland, Meharry Med. College; William A. Bailey, Cincinnati, Wayne Univ.; Robert W. Ballard, Nelsonville, New York Med. College; Chester D. Biery, Akron, George Washington Univ.; William E. Birmingham, Cleveland, Hahnemann Medical College; John F. Boyd, Cleveland, Univ. of Mich.; E. Kleona Brown, Akron, Univ. of Pennsylvania; John J. Butler, Wooster, Univ. of Rochester; Leonard P. Caccamo, Youngstown, Bowman-Gray; Thomas J. Collins, Cincinnati, Northwestern Univ.; Lewis W. Coppel, Chillicothe, Univ. of Mich.

Ralph E. Cotter, N. Madison, Univ. of Pittsburgh; Robert J. Davis, Cincinnati, Johns Hopkins Univ.; James K. DeVore, Cleveland, Univ. of Okla.; Donald R. Dockry, Painesville, St. Louis Univ.; Herman O. Dreskin, Cincinnati, George Washington Univ.; R. Vance Fitzgerald, Toledo, Northwestern Univ.; James M. Fraser, Bellevue, George Washington Univ.; James Rowland Gay, Columbus, John Hopkins Univ.; Robert J. Goodall, Cleveland, Univ. of Tenn.; Lee B. Grant, Cincinnati, Univ. of Louisville; Frank W. Gwinn, South Point, Univ. of Louisville; Robert A. Hays, Cleveland, Tufts Medical College; David B. Heller, Dayton, Jefferson; Oliver A. Horak, Sandusky, Univ. of Nebraska; Frederic M. Howard, Toledo, Harvard Univ.

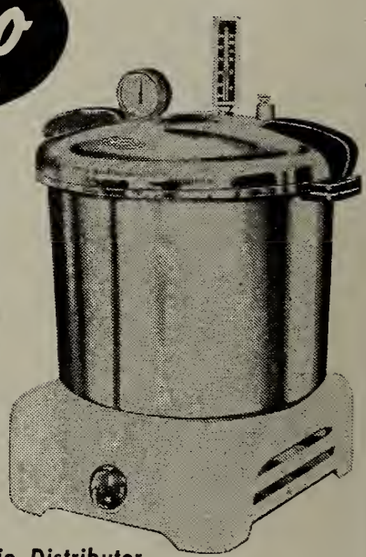
Ernest Q. Hull, Gallipolis, Northwestern Univ.; Wendell E. James, Akron, Univ. of Vermont; Ralph H. Jamison, Warren, Duke Univ.; Edward H. Jones, Jr., Youngstown, Washington Univ.; Francis W. Joyce, Salem, George Washington Univ.; John H. Keil, Jr., Columbus, Univ. of Pittsburgh; Howard A. Keiser, Lorain, Univ. of Mich.; John A. Kmieck, Parma, St. Louis Univ.; Charles R. Lambert, Rock Camp, Univ. of Louisville; Samuel D. Loube, Cincinnati, George Washington Univ.; Bernard M. Mansfield, Galion, Univ. of Louisville; Joseph P. Martin, Cleveland, Howard Univ.; Joseph M. Mazzei, Alliance, Univ. of Pittsburgh; Mor James McCarthy,

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John H. Sanders, Lakewood, Univ. of Mich.; Kenneth F. Schoenrock, Toledo, Albany Medical College; Alvin P. Shapiro, Cincinnati, Long Island College; Maxwell B. Shaw, Dayton, Long Island College; William Sinclair, Jr., Cleveland, Columbia Univ.; Joseph L. Steinem, Cincinnati, Indiana Univ.; Clyde G. Sussman, Zanesville, Indiana Univ.; Sarah E. Sykes, Cleveland, Woman's Medical College of Philadelphia; John J. Tansey, Toledo, Univ. of Mich.; Fred R. Thompson, Massillon, Univ. of Ill.; Floyd R. Town, Lancaster, Univ. of Mich.; Philip H. Welch, Columbus, Univ. of Vermont; MacDonald Wood, Cincinnati, Northwestern Univ.

American Heart Association Promotes Research

Research awards totaling $250,000 have been allocated by the American Heart Association to 26 investigators and six medical schools and hospitals for studies in heart and circulatory disease, it was announced by Mr. A. W. Robertson, chairman of the association's board.

The awards include two to established investigators engaged in independent research, 24 research fellowships to younger scientists, six grants-in-aid to institutions, and provide additional funds for basic research and cooperative research studies.

Cooperative research studies will receive $37,000 (15 per cent of the total research fund). Of this amount, $16,170 will be spent for establishment of a special training program for cardiovascular investigators under Dr. Carl J. Wiggers at Western Reserve University.

Among recipients of research fellowships is A. A. Brust, Cincinnati General Hospital, whose study is in hypertension.

The Montgomery County Medical Society is observing its 100th anniversary this year and is planning a celebration for October. The society was founded September 13, 1849.

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Air Surgeon Initiates General Practice Branch

The Air Surgeon recently announced the initiation of a General Practice Branch in the Air Surgeon's office, to be charged with the development of training opportunities and careers for general practitioners serving at U. S. A. F. installations.

According to current Air Force organization, approximately 70 per cent of physicians serving with U. S. A. F. units are general practitioners. Of the remainder, five per cent are staff and administrative personnel and 25 per cent are specialists.

Initiation of the new General Practice Branch was considered imperative by the Air Surgeon who characterized the general practitioner as "the backbone of the Air Force medical service."

Under the new program the general practitioner will be enabled to enter into a proposed residency program to be operated in the General Hospital setup. The residency program will offer the general practitioner access to latest technical developments in medical and surgical specialties. Special emphasis will be placed on internal medicine, surgical practices, pediatrics and obstetrics.

The new General Practice Branch will work cooperatively with the Surgeon General's career program for medical officers.

Expanded Hospital at Cambridge Is Dedicated

Open house was held on May 12 for the dedication of the remodeled St. Francis Hospital in Cambridge, where an expansion program has enlarged the facilities to approximately 114 beds. There are 23 bassinets in the nursery at present.

The new addition is only part of an over-all expansion program which is expected to be completed within the next five years. Present plans are to expand the hospital to a capacity of 150 beds.

The hospital is operated by the St. Francis Hospital Association, a non-profit organization, under direction of Dr. F. C. Huth and Dr. Paul O. Huth.

The open house was heralded by a "St. Francis Hospital edition" of the local *Daily Jeffersonian.*

The final tabulations of the number of births and maternal deaths in 1947 by the National Office of Vital Statistics indicate a new record low maternal mortality rate of 1.3 per 1,000 live births in the United States. The comparable rate in Ohio in 1947 was 1.12.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

ADAMS

Dr. C. Rowell Hoffmann of Cincinnati discussed "Practical Points in Diagnosis and Treatment of Duodenal Ulcers" at the April 27 meeting of the Adams County Medical Society. Plans for the proposed hospital for Adams County were discussed at the business session.

CLINTON

Dr. C. E. Richards of Dayton was guest speaker for the March 5 meeting of the Clinton County Medical Society at Wilmington where he spoke on "Infections of the Urinary Tract."

Dr. Reyburn McClellan of Xenia spoke on the subject, "The Patient Examines the Doctor," at the May 3 meeting of the Society. Dr. Edmond K. Yantes, Wilmington, reported on happenings at the Annual Meeting of the Ohio State Medical Association in Columbus.

HAMILTON

At the May 3 meeting of the Academy of Medicine of Cincinnati, Dr. Erich Lindemann, Massachusetts General Hospital and Harvard University Medical School, spoke on "Some Recent Contributions of Social Science to Medicine." At the May 17 meeting, Dr. Robert E. Gross, Harvard University Medical School, spoke on "Some Problems in Pediatric Surgery."

HIGHLAND

At the May 4 meeting of the Highland County Medical Society, Dr. Nathan Shapiro of Cincinnati spoke on "Bleeding From Gastro-Intestinal Tract."

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

At the scientific session of the Clark County Medical Society, held on April 18, Dr. Vinton E. Siler, University of Cincinnati College of Medicine, spoke on "Surgery of the Hand." Dr. Katherine Dodd, University of Cincinnati College of Medicine, spoke on the subject, "Treatment of Diarrhea in Children," at the May 16 meeting.

DARKE

"Diseases of the Larynx and Bronchoscopy," was the subject of a talk by Dr. Nathaniel Soifer of Dayton at the May 17 meeting of the Darke County Medical Society in Greenville. Attorney Howard Eley, Darke County prosecutor, discussed pending matters pertaining to unlicensed practitioners.

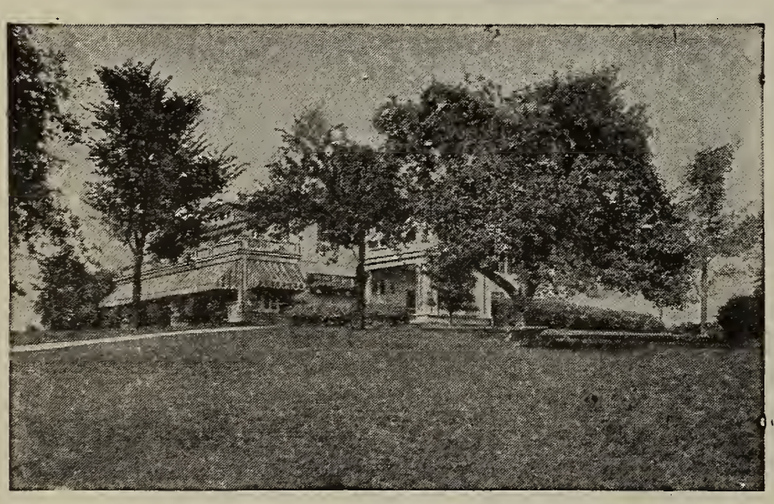
MIAMI

Wives of members of the Miami County Medical Society were guests of members for the May 5 meeting held at the Troy Country Club. Dr. Howard Dittrick of Cleveland gave a talk on "Vagabonds on Medical Trails." It was announced that the June meeting would be held with the Shelby County Medical Society in Sidney.

MONTGOMERY

Dr. Eugene B. Ferris, Jr., University of Cincinnati, College of Medicine, spoke on the subject of psychosomatic factors in hypertension at the May 13 meeting of the Montgomery County Medical Society in Dayton. Frank T. Bow, counsel for the U. S. Senate Committee on Expenditures, Washington, D. C., outlined the findings of his committee.

Members of the general practice section of the Society at the April 24 meeting heard a dis-



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cussion entitled, "The Patient With Diabetes," by Dr. I. Arthur Mirsky, May Institute for Medical Research, University of Cincinnati.

On April 24 Dr. William Bates, University of Pennsylvania School of Medicine, spoke to the Dayton Surgical Society on the subject of the relationship between nerve pains and abdominal ailments.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

SENECA

Dr. A. R. Klopfenstein of Toledo spoke on the subject of "Kidney Disease" at the April 12 meeting of the Seneca County Medical Society in Tiffin.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

The May program for the Academy of Medicine of Toledo and Lucas County included the following:

General Meeting, May 6—Dr. Carll S. Mundy, vice-president of Ohio Medical Indemnity, Inc., discussed Blue Cross and Blue Shield Plans. For the scientific discussion, Drs. Evan V. Shute and Wilfred E. Shute of London, Ontario, Canada, spoke on "Vitamin E in Cardiovascular Conditions."

Section of Pathology, Experimental Medicine and Bacteriology, May 13—Dr. Jerome W. Conn, University of Michigan Medical School, spoke on "Experimental Diabetes in Man."

Medical Section, May 20—Dr. Dwight M. Palmer, Columbus, spoke on "Early Recognition of Mental Disease."

Surgical Section, May 27—Dr. Earle B. Kay, Cleveland, spoke on the subject, "Treatment of Lesions of the Esophagus."

WOOD

The Wood County Medical Society held its regular meeting at the Everglades Restaurant, Perrysburg, April 14. Dr. Paul Orr presided and gave a review of the Annual Conference of Society Officers held in Columbus March 20. Dr. Orr reported this as an exceptionally effective meeting and exactly of the type required in the present campaign for freedom of medicine.

Dr. C. G. Aurand of Bowling Green who has just returned from an extended trip to Hawaii, gave an interesting talk on medical conditions in the islands and some surprising information on the political trends.

The paper of the evening was read by Dr. Spencer W. Northrup, commander, U. S. N., on "Injuries Produced by the Atomic Bomb." Dr. Northrup gave a description of the lesions likely to be encountered in patients at varying distances from the center of the explosion and direc-

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tions for treatment. He also pointed out that in the event of the bombing of a large city it would be necessary to evacuate patients to the smaller hospitals over a wide area thus making the attact a matter of grave concern to the distant communities. Dr. Northrup is a member of the Toledo Clinic.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

LAKE

"Whats New on the Legislative Front" was the topic of an address given by Mr. George H. Saville, Columbus, public relations director for the Ohio State Medical Association, when he spoke at a dinner meeting of the Lake County Medical Society on May 10 at Sunset Inn, Willoughby. A general discussion on public relations was held. Dr. Frederick J. Dineen was general chairman of the meeting and Dr. Paul Reading, program chairman.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

PORTAGE

Dr. H. B. Elwell, Jr., Garrettsville, gave a talk during which he showed a film on the "Problem Child," at the May 5 meeting of the Portage County Medical Society at Robinson Memorial Hospital in Kent.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Visiting speakers at the May 5 meeting of the Belmont County Medical Society and Auxiliary included Dr. Carl A. Lincke, Carrollton, President of the Ohio State Medical Association, Dr. R. J. Foster, New Philadelphia, Seventh District Councilor, and Mr. Charles S. Nelson, Columbus, Executive Secretary of the Association.

A late afternoon scientific session was held with Dr. Leo H. Criep, University of Pittsburgh Medical School, who spoke on "Allergies." Dinner was followed by the business session.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

ATHENS

A committee from the Athens County Medical Society met with members of the Clinic Blues benefit committee and the superintendent of nurses at Sheltering Arms Hospital and approved the financial report of the Clinic Blues benefit show presented in March.

GUERNSEY

The Guernsey County Medical Society held its regular meeting on April 7 at the Hotel

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Berwick with Dr. William L. Denny in charge. Plans for the pre-school clinic were discussed and it was decided to hold it on June 2 with the following in charge: Dr. E. E. Conaway, Dr. J. D. Knapp, Dr. Robert A. Ringer, Dr. H. L. Wells, and Dr. J. A. L. Toland. Dr. Denny gave a report on the County Society Presidents' and Secretaries' meeting in Columbus on March 20. A copy of the address given by Mr. Saville was sent in the form of a chain-letter to all members of the society.

A discussion of the problem of patients securing a physician for emergencies on Thursdays, Sundays and holidays was held at the May 7 meeting. A motion was passed unanimously favoring the following plan and asking that adequate newspaper publicity be given to inform the public as to the procedure. The procedure is as follows: (1) Call your own physician at his home. If he is not there (2) take patient to one of the hospitals, if he can be moved. (3) If patient cannot be moved, call one of the hospitals and ask for your own physician. If he cannot be located a substitute will be secured.

The Society was advised that the finance commission of the City Council had definitely rejected the plan to consolidate the city and county health departments. The Society reaffirmed its stand in favor of the merger and suggested a meeting with the council, at which members of the Ohio Department of Public Health, physicians and other interested persons could present their views on the subject.

Reports on the Annual Meeting of the Ohio State Medical Association were given by Dr. Robert Ringer, delegate, and Dr. M. C. McCuskey.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

HOCKING

Dr. Richard C. Jones of Logan is chairman of the medical advisory committee appointed by the Hocking County Medical Society to work with the Hocking County Red Cross Chapter's new blood program.

SCIOTO

Guest speaker for the May 9 meeting of the Hempstead Academy of Medicine in Portsmouth was Dr. Alfred L. Weiner of Cincinnati whose subject was "Diagnosis and Treatment of Skin Diseases in General Practice."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FRANKLIN

Dr. Nathan Chandler Foot, formerly with the University of Cincinnati College of Medicine, but now with Cornell University Medical College, spoke before the May 2 meeting of the Co-

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lumbus Academy of Medicine on the subject of cancer.

At the May 16 meeting of the Academy, Dr. James H. Sterner, director of the laboratory of industrial medicine for Eastman Kodak Company, spoke on "Medicine in the Atomic Age."

MADISON

The Madison County Medical Society and the Woman's Auxiliary heard reports of the Annual Meeting of the Ohio State Medical Association at a joint dinner followed by separate meetings. Dr. Ernest Crouch reported happenings at the meeting to members of the Society.

ROSS

The Ross County Medical Society held a joint meeting on May 6 with the Woman's Auxiliary. There were 50 persons present. The guest speaker was Dr. Robert E. S. Young of Columbus who spoke on "Government Medicine."

UNION

Members of the Union County Medical Society were guests of Dr. W. P. Drake at his home in Richwood for the May 10 meeting of the Society. Several Kenton doctors also were guests.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

ERIE

Members of the Erie County Medical Society were entertained with dinner at the Log Cabin Inn, Bay View, by members of the Woman's Auxiliary. Speaker of the evening was Dr. Ross M. Knoble, Sandusky, president-elect of the Ohio Academy of General Practice, who spoke on the purposes of that organization. Dr. Henry W. Lehrer, Sandusky, director of the Lake Erie District of the Ohio Academy of General Practice, also spoke briefly on work in his district. A play was presented by members of Harlequins, local little theater group.

LORAIN

Dr. John Tucker of Cleveland spoke on "Chronic Arthritis" at the May 10 meeting of the Lorain County Medical Society. A dinner was held at the Spring Valley Country Club, Elyria, followed by the scientific program and a business meeting.

RICHLAND

The first half of the April 14 meeting of the Richland County Medical Society represented a duplicate of the County and State Officers' and Committeemen's Meeting held in Columbus March 20. Four speakers abstracted the talks given by Mr. Nelson, Mr. Saville, Mr. Rember and Mr. Gross, after which a discussion period was held.

A speakers' bureau was authorized. The problem of night calls and the advisability of having a grievance committee were discussed.

The April 28 meeting of the Society was held at the Mansfield General Hospital. Following a

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GYNECOLOGY—Intensive Course two weeks, starting June 20, Sept. 26. Vaginal Approach to Pelvic Surgery, one week, starting June 13, Sept 19.

OBSTETRICS—Intensive Course, two weeks, starting Sept. 12.

MEDICINE—Intensive General Course, two weeks, starting June 13. Gastroenterology, two weeks, starting June 27. Gastroscopy, two weeks, starting June 13, July 18. Electrocardiography & Heart Disease, two weeks, starting July 18.

PEDIATRICS—Diagnosis & Treatment of Congenital Malformations of the Heart, two weeks, starting June 13. Personal Course in Cerebral Palsy, two weeks, starting August 1.

DERMATOLOGY—Formal Course, two weeks, starting June 13. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 26. Ten Day Practical Course in Cystoscopy every two weeks.

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buffet dinner, a short business meeting was conducted by Dr. R. R. Crawford, president. The speaker of the evening was Dr. Hymer L. Friedell, University Hospital, Cleveland, who spoke on "Atomic Energy."

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 DORMAN DRIVE, PORTSMOUTH

(Editor's Note—Since Mrs. Meltzer is the incoming chairman of the publicity committee, all items for this column should be sent to her. She has requested that publicity chairmen of all county organizations correspond with her so that she may bring her records up to date. Copy for this column must be in *The Journal* office by the 10th of the month preceding date of publication, therefore, items should be sent to Mrs. Meltzer for compilation well in advance of that date.)

ASHTABULA

Mrs. John Kanne was guest speaker at the March meeting of the Woman's Auxiliary to the Ashtabula County Medical Society. A dinner at the Hotel Ashtabula preceded the short business session and the talk by Mrs. Kanne who spoke on the "Romance of Oriental Rugs." Members attended from Conneaut, Kingsville and Ashtabula.

The April meeting of the Ashtabula Auxiliary took the form of a reception for registered nurses at the Nurses' Home, with 50 in attendance. A play based on psychoanalysis was presented by members of the Ashtabula Little Theatre group. Mrs. C. C. Campbell and Mrs. C. C. Roller poured coffee following the program, spring flowers and white tapers marking the table. Mrs. O. J. Lighthizer served as program chairman.

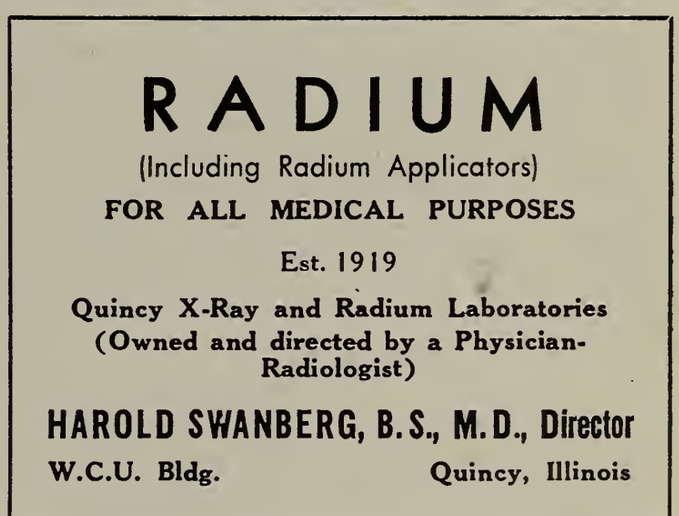
BUTLER

The Colony was the scene of the festive April meeting of the Woman's Auxiliary to the Butler County Medical Society. A luncheon preceded the business session, election of officers and an afternoon of social activity. Mrs. Howard Hunter presided over the business session. Those who will serve for the coming year are president-elect, Mrs. Paul Ivins; vice-president, Mrs. John Carter; recording secretary, Mrs. William Neel; corresponding secretary, Mrs. Jack Harris; treasurer, Mrs. Robert Wilson; director, Mrs. A. J. Mackie. Mrs. W. H. Henry, president-elect for this past year, became the new president. Bright green potted plants in unusual containers in the shapes of rolling pins, hats, etc., provided the striking favors at the luncheon.

CLARK

The Woman's Auxiliary to the Clark County Medical Society received top recognition, for the second successive year, by again winning first prize in the Credits and Awards contest conducted by the Woman's Auxiliary to the Ohio State Medical Association. The achievement award was made on the basis of a "point system," credit being given for outstanding program accomplishments, excellence of reports, membership and attendance, and committee activities. The Auxiliary placed with a perfect score of 100. Ten auxiliaries received scores above 90, and 5 scored above 95. Mrs. Frank Anzinger,







Jr., president of the Clark County auxiliary, accepted the award of $15 in the name of the local group.

The annual election of officers for the Clark County group was held at the May luncheon meeting at Ker-Deen Inn. Mrs. H. S. Milligan was hospitality chairman. An "In Memoriam" service was held for the late Mrs. J. D. LeFevre and Mrs. C. S. Ramsey. The Nurse Recruitment and Fellowship Committee under the chairmanship of Mrs. E. P. Greenawalt was praised for its activities for "Career Day." Members of that committee had driven over 1,500 miles by May 1 to aid in the nurse recruitment program of the City Hospital. The showing of five health films for 16 schools has been arranged by the Health Education Committee, Mrs. T. A. Gardner and Mrs. Robert Arthur, co-chairmen.

LUCAS

The April meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County took the form of an "open session," following the group's monthly luncheon and business discussion. The open meeting which was held in the auditorium had as its guest speaker, Dr. N. J. Dallis, Toledo, whose subject was "Psychosomatic Medicine." A ten-minute question and answer period followed the doctor's lecture. One hundred guests, representing 18 Toledo women's organizations were present, in addition to the 55 auxiliary members. This public meeting was scheduled in accordance with the custom of the auxiliary to sponsor a professional program of interest to non-members. Arrangements were handled by the program committee, Mrs. Bernhard Steinberg, chairman. Mrs. F. P. Osgood, social chairman, and her committee, also assisted with the public event.

MONTGOMERY

The Auxiliary to the Montgomery County Medical Society met on April 12 in the auditorium adjoining the county medical office. The retiring president, Mrs. A. D. Cook, gave her annual report and installed the new officers. For her tireless efforts in organizing the auxiliary, the membership presented Mrs. Cook with a gift. The program part of the meeting was devoted to a discussion on interior decorating.

SCIOTO

In celebration of the ninth anniversary of the organizing of doctors' wives in the state, the Woman's Auxiliary to the Hempstead Academy of Medicine gave a luncheon and special program in April at the Elks Country Club. Seventy-five members and guests were present for the program—"A cavalcade of the past, highlighting special activities of the local organization since its inception in the fall of 1940." The program was in charge of the six past presidents.

TUSCARAWAS

The Woman's Auxiliary to the Tuscarawas County Medical Society held a luncheon meeting at Union Country Club in Dover in April. Twenty-three members and three guests were present. Miss Barbara Packer of New Philadelphia gave an interesting talk on socialized medicine in England. Miss Packer, until recently a nurse in a London hospital, gave many examples of health conditions today under socialized medicine in that country.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

School Health Education, by Delbert Oberteuffer, Ph. D., ($3.25. *Harper & Brothers, New York City)* is a textbook for teachers, nurses, and other professional personnel by a professor in the Ohio State University. It gives a comprehensive view of the many aspects of a school health program and describes those procedures which are proving most successful at the present time. It would be a splendid public service if each physician who is a parent of children of school age would read this text carefully and get into the P. T. A. and help his wife improve the health of his neighbor's children and his own. Education today is nothing so much as the challenge of intelligent parents. Who is better fitted to take the lead than the young physician? Why earn money to send to Washington to double back to your town? Why not do the job yourself?

Practical Aspects of Thyroid Disease, by George Crile, Jr., ($6.00. *W. B. Saunders Company, Philadelphia)* presents the picture of diseases of the gland in such a way that medically trained readers may gain a better understanding of the aims of the surgeon, and the surgically trained reader may understand better what the internist and radiologist are able to accomplish.

Handbook of Disease of the Skin, by the Richard Suttons ($12.50. *C. V. Mosby Company, St. Louis)* is intended to supply a text useful to medical students, practitioners and specialists. It is more complete than the authors' **Synopsis** and less voluminous than the fourth edition of the **Dermatology.**

Atlas of Peripheral Nerve Injuries, by William R. Lyons and Barnes Woodhall, ($16.00. *W. B. Saunders Company, Philadelphia)* is another effort to present these pathologic changes as they have been seen in war casualties treated in Walter Reed and Halloran General Hospital during 1943 through 1945.

The Uses of Penicillin and Streptomycin, by Chester S. Keefer, M. D., ($2.00. *University of Kansas Press, Lawrence, Kansas)* contains the Porter Lectures, Series 15—Penicillin in Medical and Surgical Practice, Streptomycin in the Treatment of Infections, Antibacterial Agents from Microbes.

Microbiology and Man, by Jorgen Birkeland, Ph. D., Professor of Bacteriology in Ohio State University, ($5.00. Second Edition. *Williams & Wilkins, Baltimore, Maryland)* is an account of the diverse properties and characteristics of micro-organisms, a description of the various tools and techniques for their handling and an inquest into their subtle relationship to everyday life. If it has been some time since you have read a text in bacteriology, then here is the book for you to review.

British Surgical Practice, under the editorship of Sir Ernest Carling and J. Paterson Ross, in eight volumes, ($15.00. Volume 5. *C. V. Mosby Company, St. Louis)* covers subjects from Hodgkin's Disease to Lympho-Granuloma Inquinale. It maintains the same high quality of text and illustrations seen in previous volumes.

Temperature and Human Life, by C.-E. A. Winslow and L. P. Herrington, ($3.50. *Princeton University Press, Princeton, New Jersey)* is a broad discussion of man's relation to his thermal environment. Both physiological reactions and physical stimuli are given due weight. It is a timely volume dealing with clothing, air condition, climate and seasons and their influence upon Health.

American Nurses Dictionary, by Alice L. Price, R. N., ($3.75. *W. B. Saunders Company, Philadelphia)* is primarily designed to meet the need of nurses. Most girls entering the school of nursing find it extremely difficult to understand the highly technical terms used in medicine and nursing. To overcome this difficulty, this book has been created by a nurse for the nursing profession, and contains definitions of approximately 25,000 words which the student nurse will meet in her daily work. There is presented a teachers' supplement to help them with the student nurse, listing the new words according to the subject under which they are first encountered.

Nutrition and the Soil, by Dr. Lionel James Picten, with an introductory essay on creative medicine by Jonathan Forman, M. D., vice-president of Friends of the Land, ($4.00. *The Devin-Adair Company, New York)* is an American Edition of the book **Some Thoughts on Feeding** reviewed on these pages. I have written an introductory essay in an attempt to integrate the work of the British students of soil-health relationships into the work of similar students in the United States who have given their attention to the same problem. This volume is therefore a report from the advanced guard as to what is going on in the unexplored land where they are deployed including the activities of the "wild men" who live out there.

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JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

The Coroner in Court

MR. CARSON HOY

I AM happy to have the opportunity of addressing this group because, in my office, we have come to realize that very often our success or failure in homicide cases depends upon the evidence obtained by the coroner and the manner in which he presents that evidence to the jury.

We feel that we are fortunate in Hamilton County in having Dr. Lyle as our coroner because he has brought to that office an enthusiasm too seldom found in public officials and has instituted reforms which have had a very direct bearing on the success of my office in homicide cases.

The Author

● Mr. Hoy, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Law, 1925; prosecuting attorney of Hamilton County, Ohio; and professor of criminal law, College of Law, University of Cincinnati.

THE CORONER AND SCIENTIFIC CRIME DETECTION

I feel that the modern coroner is as much a peace officer as the police or prosecutor, and it behooves him, therefore, to become familiar with modern methods of scientific crime detection.

In the past we have had entirely too many deaths in which the records are marked "Cause of death unknown." I realize, of course, that it is not always possible to determine definitely the cause of death, but I do feel that coroners should be provided with a sufficient budget to enable them to make a complete investigation in the case of every unusual death.

Naturally such an investigation should be impartial, but if there is any possibility of foul play, the coroner should use every means at his command to ferret out the truth.

To that end, it seems to me that the coroner should be provided with some of the facilities of modern crime detection, and should familiarize himself with their use. While it is true that the coroner usually has access to the facilities of local police departments and those of the Federal Bureau of Investigation, these facilities will be of little assistance unless the coroner is familiar with modern scientific crime detection methods in order that he be able to recognize situations in which scientific tests might be useful in arriving at his conclusion.

VISITING THE SCENE OF THE HOMICIDE

We prosecutors feel that we are working under a distinct handicap because, in most counties, means have not been provided whereby a medical examiner can be called to the scene of every homicide before the body is moved.

For one thing, we are never able to form an estimate of the time of death because the coroner does not see the body until it arrives at the morgue. Very often an estimate of the time of death would be very helpful to the solution of a case. Time after time we have checked the activities of suspects at or about the time of the death of the decedent, but our efforts are of little avail because we have nothing upon which to base an estimate of the time of death.

There are many other items of evidence at the scene of a homicide which would be im-

A paper read at the Ohio State Coroner's Association Meeting on May 13, 1948, at Cincinnati, Ohio. Submitted for publication November 22, 1948.

mediately apparent to a medical examiner but which might escape the eye of a police officer.

MARKING AND PRESERVATION OF EVIDENCE

A mistake which is commonly made by medical men who are not familiar with trial work is their failure to properly mark and preserve objects which might be used as evidence in a trial.

When you remove a bullet from a body, be sure to put some identifying mark on it so that when it is shown to you on the witness stand you can state positively that it is the same bullet you found and can show why you are sure. Unless this is done, ballistic tests are utterly useless. Suppose that you remove a bullet during an autopsy and the suspect is not arrested until months later when you have almost forgotten about the case. If the suspect is in possession of a revolver and if you still have the bullet and can positively identify it, ballistics tests can be made which will positively prove that the suspect's gun caused the death of the decedent. If, however, you have misplaced the bullet or if it is not so marked that you can positively state that it is the one which you removed, we might never be able to connect the suspect with the murder.

The same applies to the clothing, parts of the body which you may decide to preserve, etc. You must put some identifying mark or label on each such item of evidence and preserve it in such fashion that you will be able to identify it, remember to what case it belongs and be able to find it when needed.

In poison cases, if parts of the body are to be preserved, they must be handled only by persons who will be available as witnesses and must be sealed so that it can be positively shown that nothing has been added or taken from the container after the examination was made. The prosecution is required, in such cases, to produce every person who handled the evidence in order to show that no one could possibly have tampered with it.

I mention these things because you, as medical men, are primarily interested in the medical aspects of an autopsy and may overlook the fact that failure to mark and preserve seemingly unimportant items of evidence may be fatal to the prosecution in the trial.

PHOTOGRAPHIC EVIDENCE

I cannot stress too strongly the value of photographic evidence in homicide cases. Especially photographs showing the nature and extent of the wounds. I know of a number of convictions obtained by my office during the past year in which jurors afterwards admitted that the photographs taken by members of the coroner's staff and admitted in evidence were the deciding factor in the case.

It must be remembered that in a homicide case the State is at a disadvantage because the jury becomes more or less acquainted with the defendant. They see him in court and hear him testify. On the other hand, they do not see the deceased and to them he is simply a name with whom they can feel no kinship. However, when we introduce photographs, the jurors have an entirely different attitude. They look at the photograph and then at the defendant and they think to themselves "so you did this." The advantage to the State is immediately apparent.

In addition, I can think of nothing more undramatic than a coroner explaining, in medical terms, the nature and extent of the wounds which he found on the body of the decedent. Even illustrating on the body of someone else does little good. Photographs of the actual wounds, however, make a deep and lasting impression upon the jury and dramatize the situation. They tend to make the jury sympathetic towards the deceased. Furthermore, after the jury has left the court room and is deliberating in the jury room, they will have forgotten most of the coroner's oral testimony, but they will still have with them the photographs which have been admitted in evidence.

THE CORONER AS A WITNESS

Every lawyer is familiar with the fact that the most intelligent witness does not always make the best witness. It matters not how well you know your subject—if your testimony is not properly presented it makes little or no impression on the jury. Consequently, it might be well to discuss some of the mistakes which are commonly made by witnesses generally and by professional witnesses particularly.

PREPARATION OF THE FACTS

First of all, it is important that you study your records thoroughly before you are called to the stand. You should be able to describe the body with regard to size, weight, age, abnormalities and wounds and be able to give dates and your opinion as to the cause of death, without referring to notes.

I have seen prominent medical witnesses absolutely discredited by juries simply because they had not prepared themselves and had to fumble through sheaves of paper to find the answer to each question asked of them on the witness stand.

Naturally, you are permitted to refer to your notes if you are asked a question about which you do not have an independent recollection, but the jury will be much more favorably impressed with your testimony if you appear to know what you are talking about and can answer from memory and without hesitation.

Another thing to remember is that you may be subject to vigorous cross-examination by defense counsel. Before taking the witness stand, therefore, you should attempt to anticipate every question which might possibly be asked you on cross-examination so that you will not be taken by surprise or be made to look foolish.

APPEARANCE AND ATTITUDE

It is well to remember that you are testifying as a professional witness and as an expert. You should, therefore, dress and act the part. Sloppy dress or flippant manner are distinctly detrimental to your effectiveness and should be avoided. You should keep in mind that a trial is very much like a theatrical performance and that the witnesses and the lawyers are members of the cast; while the jury is the audience.

I have seen witnesses who made the mistake of trying to impress the lawyers by making "wise cracks," etc., in their testimony, totally oblivious of the fact that they were making a very poor impression upon the jury. Remember, it is the jury which decides the case—not the lawyers.

Remember, too, that homicide is a serious business and that levity is not becoming, nor has it any place, in a murder trial.

USE OF MEDICAL TERMS

Many physicians who are called as witnesses make the mistake of trying to impress the court and the lawyers by couching their testimony almost entirely in medical terms. They feel perhaps that people will get the impression that they must be very intelligent to be able to use these large words. Most practicing lawyers and most judges are fairly familiar with ordinary medical terminology, but most jurymen are not; and if you insist on the use of such terminology you not only do not impress the jury, but might as well testify in a foreign tongue. Your testimony goes completely over their heads and you have told them nothing.

I repeat, therefore, that in order to be effective as a witness, you must remember that you are testifying for the benefit of the jury and no one else and you must present your testimony in the language of the people to whom you are talking.

This does not mean, however, that medical terminology must be eschewed altogether. It is perfectly proper to make sparing use of medical terms, provided that you pause after using each such term and explain it. In this way you can impress the jury with your medical knowledge and at the same time be understood.

CONCLUSION

In conclusion, I would like to say that we prosecutors are deeply grateful for the cooperation which we have always received from our coroners. We realize that you are limited by the budgets within which you must work and must do the best you can with what you have.

We feel, however, that if the public were made aware of the good that might be accomplished if coroners were provided with the means and facilities whereby their skill and talents might be utilized to the fullest extent, such means and facilities might be forthcoming.

The public must be awakened to the mounting cost of crime and must provide proper tools with which to combat it, for it is only by complete cooperation among all law enforcement agencies working with the best facilities obtainable that the war against crime can be successfully waged.

Geriatrics

Another important principle in the treatment of the aged is relief of pain and discomfort. In the acute states, even when the patient is confused or delirious, a nagging discomfort may be a serious handicap to recovery. One should develop the habit of routinely asking himself, before leaving the bedside, "Is this patient comfortable?" Often the ill patient is unable to explain why he is so miserable. It is up to the physician to consider such possibilities as position in bed, which may seem natural but is actually uncomfortable because of stiffness of the back or joints; or a distended bladder; or fecal impaction; or the many other minor disturbances that interfere with rest. A little thought about the matter and a careful examination may be of inestimable help in the recovery from an acute illness.

In the minor conditions, comfort also should be looked upon as an important part of the physician's responsibility. Hot tub baths or salicylates may be used to relieve stiff and aching muscles; ill-fitting dentures should be readjusted. Flatulence and constipation should be regarded as worthy of real treatment, not just something to be waved aside. Urinary frequency that interferes with recreation in the daytime and with sleep at night is certainly more than a minor matter and calls for relief.

The use of drugs in the treatment of minor complaints can be developed into an art. Sedatives may remove the terrors of long, wakeful nights. A cocktail or highball may stimulate the appetite and give a sense of well-being that promotes digestion. One must guard against overdosage, of course, but the judicious use of drugs may change the entire clinical picture of old age. —Roy Ross Snowden, M. D., Pittsburgh, Pa., Pennsylvania Medical Journal, Volume 52, Number 8, May, 1949.

Diphtheria

PAUL Q. PETERSON, M. D.

THE appearance of diphtheria in epidemic form dates far into antiquity, and the diagnosis of the infection presented extraordinarily perplexing problems to early physicians. Before the advent of laboratory diagnosis, this condition was undoubtedly confused with other pathologic states affecting the throat, mouth and adjacent tissues—such as streptococcal, fungal, or Vincent's infections, and nutritional disturbances—which might have occurred alone or which might have been superimposed upon the diphtheritic infection. However, in spite of these complications, certain characteristics of diphtheria clearly indicate the disease existed as early as the Sixth Century and might have been known even for many years prior to that time. It was not until the early Nineteenth Century that the French physician, Brettoneau, placed the clinical diagnosis on a reasonably firm foundation. The diagnosis could not be completely accurate, nevertheless, until supplemented by the discovery of the diphtheria bacillus by Klebs in 1883, and the demonstration of its etiologic relationship to diphtheria by Loeffler in 1884.

In 1888, Roux and Yersin demonstrated that the diphtheria bacillus exerts its disease-producing effect by the formation of a soluble poison—an exotoxin which is produced in culture and which may be separated from the bacterial cell and is capable of producing characteristics of the infection in animals. Within a short time, Behring found the animal body was capable of responding to minute sublethal doses of this toxin by the elaboration of a substance capable of specifically neutralizing the poison, called antitoxin, and in 1891 the sera from immunized animals was first employed in the treatment of clinical diphtheria. In 1913, Schick developed the skin test for determination of the immune status of an individual by injecting minute amounts of the toxin intradermally and measuring the skin reaction.

The method for controlling diphtheria in population by mass immunization procedures was first suggested by Theobald Smith in 1909, and developed in the form of a toxin-antitoxin mixture by Behring in 1913. This product was first employed on a mass scale for the protection of children, by Park in 1922. In 1923, Ramon showed that formalin treated toxin, known as anatoxin, and now commonly called toxoid, had advantages as an immunizing agent over the toxin-antitoxin mixtures. Thus, since 1923 the knowledge and tools necessary for the treatment and prevention of diphtheria have been available to the profession.

Submitted February 14, 1949.

The Author

● Dr. Peterson, Columbus, Ohio, is a graduate of University of Illinois College of Medicine, 1938; received M. P. H. degree, University of Michigan, 1946; fellow, American Public Health Association; chief, Bureau of Direct Services, Ohio Department of Health.

Since the introduction and widespread use of immunizing antigens, there has been a constant decline in the incidence of diphtheria. During this 25-year period there has been continual argument and doubt in many minds as to whether this decline in the incidence of the infection was due to the widespread use of the immunizing antigen, or whether it was a coincidental, but unrelated, change in the pattern of the disease in the population. It has been established that diphtheria occurs in definite but irregular cycles of prevalence and virulence, and on this account many epidemiologists have discounted the decreases since immunization.

The diphtheria experience during World War II has definitely shed some light on this particular problem of the disease. Immediately prior to, and during hostilities in Europe, there was a pronounced increase in the incidence of the infection in central and northern European countries. At the same time there was an apparent resistance to treatment. English studies during this period demonstrated the organism to be of gravis and intermidius strains; however, the work was not confirmed by bacteriologists from this country.

The data presented in Table 1 show the experiences of these countries insofar as obtainable during these years. The important consideration in the study of this material is that of the countries shown (1) only Denmark had anywhere near an adequate level of its population immunized by artificial immunization procedures and despite being disorganized due to invasion as completely as any country, it did not experience as great an increase in the incidence of the infection as its neighboring countries. (2) England and Wales were the only countries which showed an actual decrease in the incidence of diphtheria during this same period and, interestingly enough, were the only

TABLE 1

Year	Diphtheria Incidence* 1937	1938	1939	1940	1941	1942	1943	1944
Austria	19,494	16,800	19,137	15,910	14,255	15,534	22,444	———
Denmark	1,348	870	1,106	860	917	1,661	2,527	3,333
France	19,187	16,800	14,019	13,568	20,018	31,466	46,539	40,230
Germany	146,733	149,490	143,585	138,397	173,161	237,037	238,409	———
Hungary	8,148	6,266	6,397	4,927	5,049	6,676	8,259	———
Netherlands	1,068	1,272	1,273	1,730	5,501	19,527	56,603	———
Norway	417	190	71	149	2,609	8,349	22,787	———
Rumania	3,242	2,272	2,279	1,839	1,103	1,612	1,879	———
Sweden	299	107	188	290	252	1,285	2,496	4,520
Eire	2,511	2,983	2,087	1,891	1,447	2,949	4,650	5,168
England and Wales	61,341	65,008	47,698	47,683	51,091	42,318	35,944	29,446

* Source of data: Epidemiological Information Bulletin, United Nations Relief and Rehabilitation Administration. 1:241-246 (March 15, 1945).

countries wherein an intensive immunization program was instituted and carried out during the time of the study. Therefore, it would appear that artificial immunization may definitely influence the incidence of diphtheria in the population in the face of an international rise in the incidence and virulence of the disease.



Graph 1

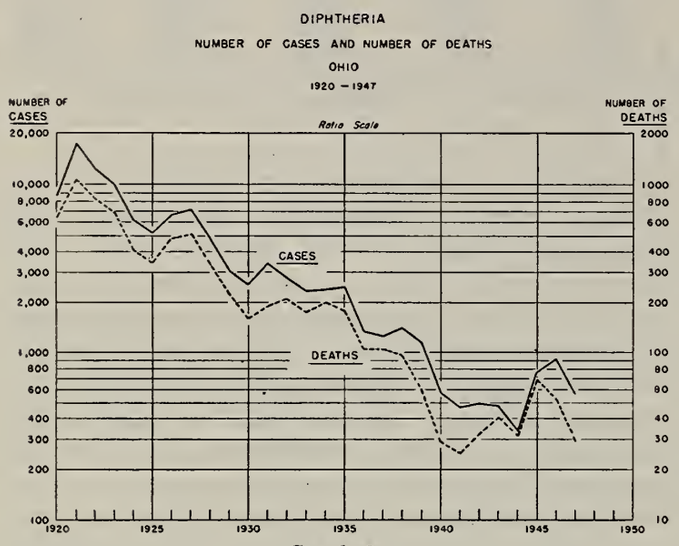
Concomitant with the decreased prevalence of diphtheria since the introduction and widespread use of the immunizing antigen, there has been a constant decrease in the crude death rate (see Graph 1). On its face value, this decrease would seem to indicate that not only has there been a decrease in the incidence and prevalence of diphtheria, but also that there has been an improved treatment for those infected with the disease. In an effort to analyze more specifically how the component parts of the program for control of the disease may have influenced this decline, the present study has been undertaken. The resource data used were secured from the state departments of health in Michigan, Illinois, and Ohio. (See Table 2.)

They represent the morbidity data on the number of cases of diphtheria reported to the official health agency, from 1920 through 1947, and also the number of deaths from diphtheria as reported on death certificates to the respective divisions of vital statistics for the same period of time. In a statistical analysis of this resource data, the possibility of fallacies which might bias deductions should be considered. In the event of this material, the assumption that the death certificates present a constant and true picture of the mortality from diphtheria through-

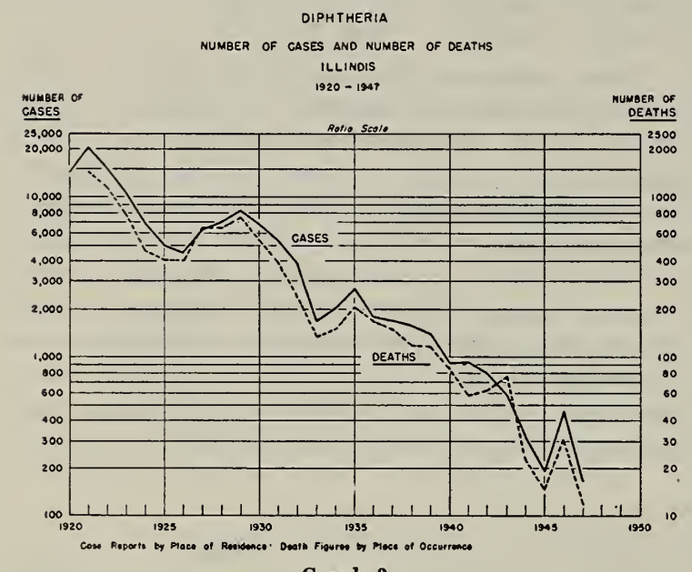
TABLE 2

Year	Michigan Cases	Deaths	Case Fatality	Illinois Cases	Deaths	Case Fatality	Ohio Cases	Deaths	Case Fatality
1920	10,360	919	8.8	14,294	———	———	8,587	639	7.4
1921	12,075	954	7.9	20,767	1,474	7.0	17,847	1,075	6.0
1922	8,513	620	7.2	15,132	1,171	7.7	12,454	830	6.6
1923	7,725	675	8.7	10,683	801	7.4	10,044	683	6.8
1924	6,011	470	7.8	6,859	472	6.0	6,232	415	6.6
1925	3,925	358	9.1	5,003	408	8.1	5,237	389	7.4
1926	5,377	677	12.5	4,529	413	9.1	6,636	483	7.2
1927	4,575	516	11.2	6,272	649	10.3	7,137	509	7.1
1928	3,724	384	10.3	7,107	649	9.1	4,843	369	7.6
1929	4,618	498	10.7	8,155	756	9.2	3,130	224	7.1
1930	3,206	299	9.3	6,843	543	7.9	2,677	160	5.9
1931	1,831	172	9.3	5,413	383	7.0	3,450	189	5.4
1932	1,188	106	8.8	3,811	240	6.1	2,788	222	7.9
1933	1,152	112	9.7	1,695	134	7.9	2,362	174	7.3
1934	614	38	6.1	2,092	153	7.3	2,385	197	8.2
1935	645	58	8.9	2,663	208	7.8	2,491	178	7.1
1936	661	52	7.8	1,784	170	9.5	1,358	105	7.8
1937	842	72	8.5	1,671	153	9.3	1,276	104	8.1
1938	619	44	7.1	1,634	120	7.3	1,410	97	6.8
1939	452	25	5.5	1,446	118	7.4	1,146	60	5.2
1940	264	20	7.5	936	86	9.1	579	29	5.0
1941	242	18	7.4	940	58	6.1	474	25	5.2
1942	245	24	9.7	816	63	7.7	504	33	6.5
1943	286	21	7.3	587	78	13.2	484	41	8.4
1944	419	32	7.6	315	23	7.3	346	32	9.2
1945	630	46	7.4	194	15	7.7	773	70	9.0
1946	385	27	7.0	469	31	6.6	931	53	5.6
1947	238	23	9.6	169	12	7.1	567	28	4.9

out the period of study, may be taken without the question of bias entering the picture. But, in the event of morbidity data, it must be assumed that these reports are incomplete, in all instances, since it is a known fact reporting of communicable diseases—even the more serious —is not complete in this country. Hence any



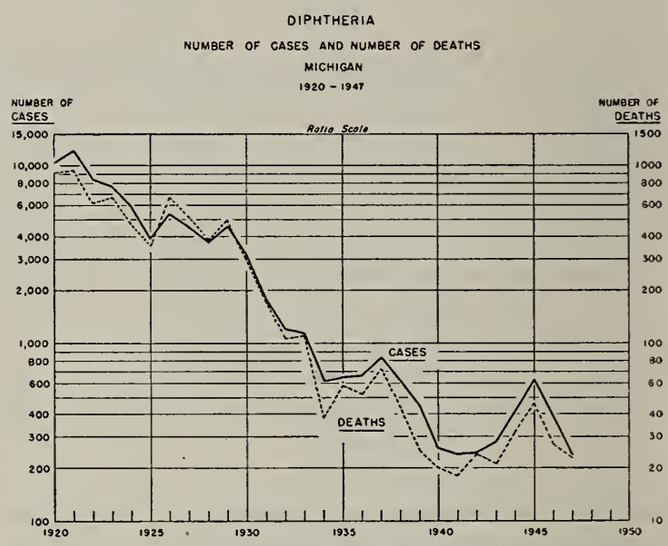
Graph 2



Graph 3

studies on the morbidity of specific infections must be predicated on the basis of incomplete and inaccurate basic data. In the case of this particular study, it is felt that because of the nature of the statistical tests applied, the data do give an index of the true status of the problem. We feel safe to assume there was more complete reporting in 1947 than in 1920; especially may this be considered as true in the state of Ohio. Prior to 1922, there was no organized local agency responsible for gathering morbidity data since the Hughes-Griswold Act, which established local boards of health did not become effective before that year. Ere that time, only the state health agency was primarily responsible for gathering morbidity data. Consequently, should there be a bias in the morbidity data as presented, the bias would be toward less complete reporting of cases early, during the period of the study, with a more complete and accurate picture during the latter part of the period under consideration. This bias would in all probability make the conclusions drawn from the data even more striking than that of accepting the figures at their face value and assuming they represent a constant picture of incomplete reporting of the prevalence of diphtheria during the 27-year period under consideration.

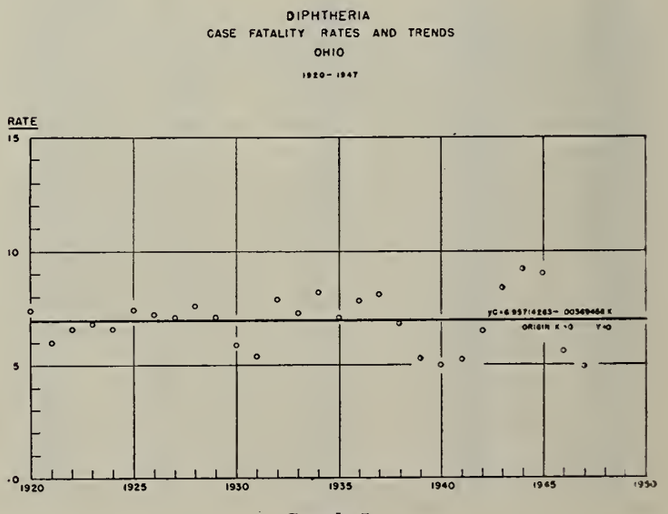
Graphs 2, 3, and 4, present the raw data shown in tabular form in Table 2. The graphic technique used is to plot the data on semi-logarithmic paper with superimposed scales, the lefthand scale for cases and the righthand scale for deaths. Such a technique makes possible a similar presentation of deaths and cases



Graph 4

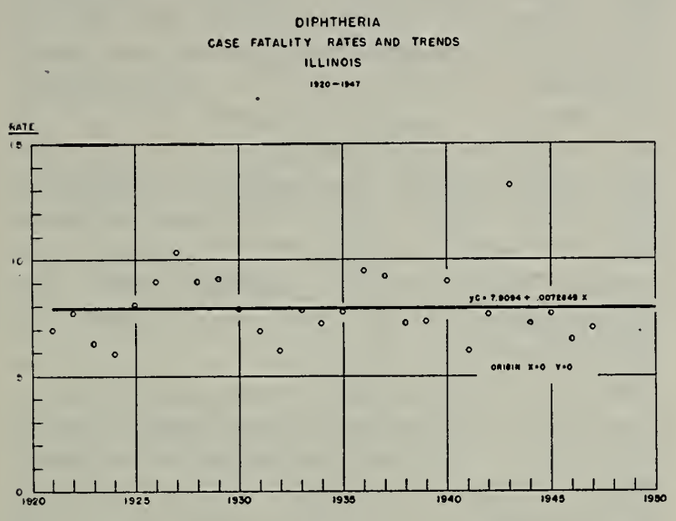
on the same graphs, so the relationship between them may be demonstrated and the relative rates of decline shown. In each instance the pattern is the same, with a constant close relationship maintained throughout.

Graphs 5, 6, and 7, present the case fatality rates for each three states included in the

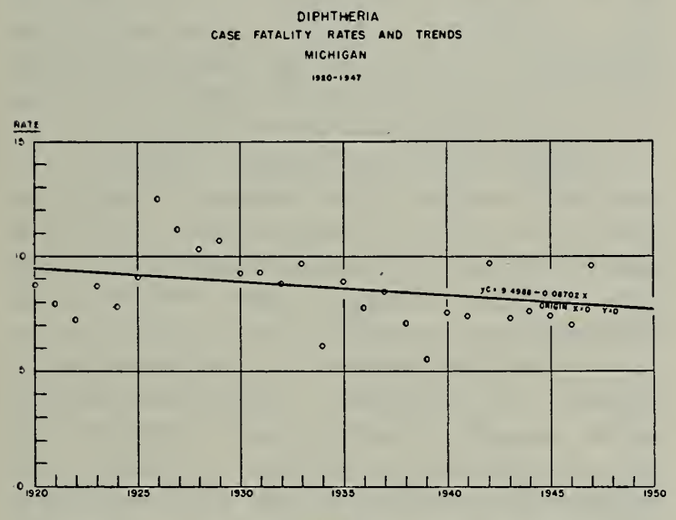


Graph 5

study. In each instance a trend line was fitted to the case fatality graph and the significance of the slope of this trend tested, to determine whether there was a significant difference in the case fatality rates over the study period for any state in the group. The test applied was by the method of least squares. The slope intercept equation is, y=a+bx, in which x is the time, y the rate, a the intercept on the x axis,



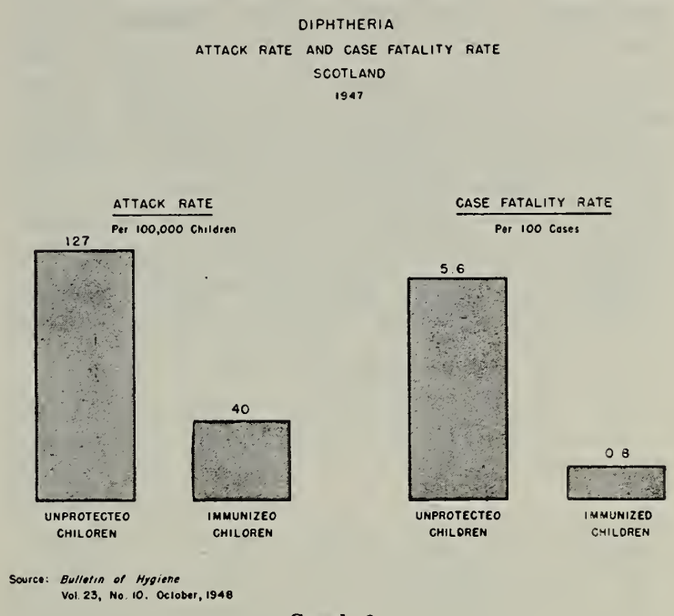
Graph 6



Graph 7

and b the slope of the line. In no instance could statistical significance be assigned to the trend in case fatality, as established from the data available. In the case of Ohio and Illinois, the slope of the line is not significantly different from zero. Michigan's experience shows a downward trend; however, a similar slope would occur one in twenty times by chance alone, and is therefore not significant at the five per cent level. It is to be noted there is an apparent slight reduction in all instances, in fatality during past few years over the experience obtained early in the study. If this reduction is continued for a sufficient length of time, significance in the trend will develop. At the present time, the probabilities are that the main influencing factor in this reduction is the effect of artificial immunization on case fatality, rather than the effect of treatment schedules.

Even though immunization is not one hundred per cent effective in the protection of individuals against an attack of diphtheria, or fatality from the disease, it is well to note in the experience of Scotland during 1947 (see Graph 8), the



Graph 8

attack rate in the unprotected group is approximately three times higher than that in the protected. Also it is interesting to note the case fatality rate is only 0.8 in the protected groups, while the higher rate of 5.6 is shown for the unprotected. So, it would appear that the slight change in fatality rate indicated in the three states under consideration, might well be due to the sharp weighting effect in the case fatality rates experienced in protected individuals who become infected with the disease.

From the data available, we may then assume the children infected with diphtheria in 1947, did not have significantly greater probabilities of recovery than those children who were infected with diphtheria twenty-seven years ago; also that the primary reason for the decrease in the crude death rate from diphtheria has been the effect of artificial immunization which has remarkably reduced, first, the prevalence of the disease, and secondly, the case fatality rate among the protected group who have been infected subsequent to receiving the specific antigen.

Such a conclusion is disturbing in the light of better facilities for treatment—in terms of hospitals and availability of supportive therapy —which were not known twenty-five years ago. Either it is necessary to assume diphtheria today is not being treated to any better advantage than in 1920—because of the nature of the infection and its pathogenesis in man—or there is failure on the part of the profession to invoke adequate therapy immediately upon diag-

nosis, or diagnosis is delayed and treatment not instituted as early as necessary.

It is a well-known fact that toxin elaborated by the bacillus, affects tissues early and produces cell death and disintegration. Peripheral nerve and cardiac tissues appear to be especially susceptible to the toxin, and undergo early fatty and hyaline degeneration, with edema and interstitial fibrosis. It is felt by the writer that after infection, if there is not immediate and complete neutralization of toxin before it has an opportunity to combine with cellular elements, an irreversible reaction takes place which results in a fatal outcome for a certain percentage of cases—no matter what treatment is instituted.

Table 3 showing cases and fatality rates according to the day of disease antitoxin is given,

TABLE 3*

	Cases	Case Fatality
Antitoxin given on 1st day of disease	225	0
" " " 2nd " " "	1,441	4.2
" " " 3rd " " "	1,600	11.1
" " " 4th " " "	1,276	17.3
" " " 5th " " " and upwards	1,645	18.7

* Source of data: Bacterial and Mycotic Infections of Man; Rene J. Dubos, Ph. D.; Publishers, J. B. Lippincott Co., 1948, pp. 207.

substantiates this position. However, the thesis is not completely true because if it were, fatality would approach one hundred per cent when antitoxin administration is delayed, and it is a known fact that the dosage of antitoxin indicated in treatment is much greater than that which would be necessary to actually neutralize the toxin which is free in the blood stream of the patient. Therefore, there may be some neutralization of toxin in tissue. Probably the toxin does not completely combine with cellular elements immediately so that there is an opportunity for the antitoxin to combine with the toxin and neutralize, in part at least, its ability to continue cellular destruction.

Suffice it is to say that in diphtheria we are dealing with an extremely lethal infection which requires immediate and heroic therapeutic measures, if the individual is to be spared either death or crippling morbidity.

The possibility of the second reason influencing the failure of a reduction in case fatality must also be considered. It is felt that due to a decreased prevalence of diphtheria, many practitioners are not seeing cases and are not on the lookout for the disease; therefore, diagnosis is being delayed until too late to completely abort the infective and toxic process. It must also be admitted that there is an apparent reluctance on the part of a majority of the profession to give specific treatment in full therapeutic doses. The seriousness of the disease, we feel, has been established adequately and it should be clear that if treatment is to be effective, it must be immediate and heroic.

Antitoxin is eliminated from the body slowly; therefore, a single large dose assures maximum immediate therapeutic protection and a sufficiently high blood level for many days, to cope with any further toxin which might be elaborated. Exact dosage, of course, depends upon the patient, site and extent of involvement, and length of infection. It may, however, be stated empirically that in no instance should the dose be less than 20,000 units, and in most cases 40,000 units more nearly approaches the indicated dosage, and 60,000 units is necessary in many cases. A single intramuscular injection should be given except in the extremely toxic case when a portion of the total may be given intravenously.

The value of penicillin as an adjunct in the treatment of diphtheria has been definitely established; however, it may not be used to supplant antitoxin. It should be given in full therapeutic doses of 20,000 to 40,000 units every three hours for at least seven days. (This same schedule has been shown to be effective for clearing the noses and throats of chronic carriers in a large percentage of cases.) It is felt the schedule as presented, is much more satisfactory than the use of single injections of any of the preparations of penicillin in beeswax, oil, etc. First, one is absolutely certain that adequate therapeutic levels are maintained; and secondly, these patients have received foreign protein in the antitoxin and are extremely toxic. Under these conditions, the probabilities of troublesome reactions from the injection of additional foreign material are increased. Supportive therapy should always be administered, especially intravenous infusions of glucose. Adrenal cortex, however, has not been proved to contribute to the therapeutics of diphtheria and therefore is not indicated.

CONCLUSIONS

From the data available, as analyzed, it appears that the only procedure which has influenced the decline in mortality and morbidity of diphtheria is artificial immunization. It, therefore, is logical to consider immunization as both a preventive and curative therapeutic technique. As such, every infant should receive antigen, beginning at six months of age, and be reinforced with booster doses at frequent enough intervals to assure a high level of protection.

SUMMARY

1. A brief historical summary on diphtheria is presented.

2. Data on diphtheria incidence in Europe during World War II are shown to indicate that

artificial active immunization will actually decrease the prevalence and incidence of the disease in a population.

3. Original data from states are statistically analyzed and indicate that case fatality has not changed significantly in the twenty-seven years of the study.

4. The only apparent reason in the decrease of the crude death rate is the influence of immunization reducing the prevalence and death thereby.

5. A brief resumé of diphtheria therapy is presented.

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Modern Science and Anesthesia

Anesthesia today takes advantage of the progress that has been made in physiology, chemistry, pharmacology, and the related sciences, and anesthesiologists have contributed their part to the progress. Exact knowledge of the physiology of external breathing, of the carriage of oxygen and carbon dioxide in the blood, of the exchange of gases in the tissues, of the pathology of the heart and brain, are only a few examples of what the competent anesthesiologist has to know of modern science, to be able to judge the condition of the patient adequately before and during the operation, and to make anesthesia safe.—Jrl. Ind. State Med. Assn., Vol. 42, No. 5, May, 1949.

Correction

In the scientific article "Rupture of Appendiceal Stump Three Months After Uneventful Appendectomy With Repair and Recovery" by Dr. Luther O. Baumgardner, which appeared in the May issue of *The Journal,* a typographical error was made in giving the amount of novocain used in one instance. The first sentence of the fifth paragraph should read—"Operation: October 11, 1942, 11:30 p. m. Spinal anesthesia was used, 150 mg. novocain in third lumbar interspace." By error the amount of novocain was printed as 1505 mg.

The Story Behind the Word: Some Interesting Origins of Medical Terms

Diphtheria:—This name is derived from the Greek term Diphthera, meaning skin, leather or membrane. Pierre Bretonneau in 1821 read a paper before the academy of medicine in Paris and proposed the name diphtheritis. This was later changed to Diphtheria by his pupil Trousseau.

Bella donna:—This term is derived from the Italian words "bella" or beautiful and "donna" or lady. It was so called because the Italian ladies of the Sixteenth Century used its juice to make their eyes seem bright and sparkling.

Digitalis:—A Bavarian botanist, Leonard Fuchs, in 1541, christened the plant digitalis. This being a translation into Latin of the German word "fingerhut." Because the flowers of the plant resemble a thimble used for sewing, the common German name was fingerhut or thimble, and this was translated into the latin equivalent digitalum.

Dengue or Dandy Fever:—The term is of uncertain origin and was first applied to the disease by the inhabitants of St. Thomas on account of the stiff awkward gait of those affected with it. The word is probably a corruption of the Spanish equivalent of dandy—denguero.

Eugenics:—This term was coined in 1883 by Francis Galton in his book "Inquiries Into Human Fertility." It is derived from the Greek word eugeneia, meaning nobility of birth.

Gauze:—This word is of historical origin and the material was so called because it was first brought from Gaza, in Palestine.

Geriatrics:—Dr. I. L. Nascher in an article published in the *New York Medical Journal* of August, 1909, coined the word geriatrics. It is derived from the Greek words "geros," meaning old age, and "Iatrikos," relating to the physician.

Influenza:—During the Seventeenth Century the Italians named it influenza because they attributed epidemics of this disease to the influence of the planets or stars.

Nicotine:—This substance is named in honor of Jean Nicot, a Frenchman, who first sent the seeds of tobacco to France in 1560 while serving as French Ambassador to Portugal.

Pellagra:—This disease was first studied by Don Caspar Casal in 1725 in Austuria, Spain. It was subsequently described in Italy in 1771 by Francisco Frapolli who first called it Pellagra. This is a corruption from the Italian description "pelle," or skin, and "agra" or rough, literally meaning rough skin.

Hordeolum:—This term is a derivative of the Latin word "hordeum" or barley. This lesion was so called from its likeness in size and hardness to a small barley corn.

—Harry Wain, M. D., Mansfield, Ohio.

The Cancer Clinic in a Small Hospital

R. J. FOSTER, M. D., and MURIEL M. YABERG, R. R. L.

IN the organization and functioning of a cancer clinic in a small community there are a great many hurdles which our colleagues in the large centers do not have to meet. However, we have proven that a cancer clinic can be operated successfully if certain fundamentals in the doctor-patient relationship are observed.

Our cancer clinic has been in operation since July 18, 1947. Clinics have been held every two weeks since that date with an average attendance of 14.6 physicians. It was sponsored and has been equipped by the Local Chapter of the American Cancer Society and is governed by the Cancer Committee of the County Medical Society.

The clinic takes only patients referred by letter or accompanied by the physician. No charge is made for the examination at the clinic. It is urged that the case be completely worked up before presentation. No cases are admitted to the clinic unless there is a question of malignancy. Subsequent to the examination, a letter summarizing the findings and recommendations of the clinic members is mailed to the referring doctor. The patient becomes acquainted with the findings and recommendations through his own doctor.

Although we call ourselves a Diagnostic Cancer Clinic, we have functioned as a true Cancer Clinic which combines diagnosis with treatment. However, we are at a variance with the Cancer Clinics in the larger centers in that the referring doctor chooses the Staff member to carry out the treatment.

The members of our Staff are in a position to furnish the usual armamentarium of treatment: surgery, electro-surgery, radium and deep X-ray therapy. We feel that this point obviates any prejudices or jealousies that might occur if the patient were channeled to a particular surgeon or radiologist for treatment. Chest and brain surgery are referred to larger centers.

Our clinic meets every two weeks on Friday at 11:00 a. m. In addition to the new cases, each house case is processed. Our hospital Staff has a ruling that each house case must be processed through the clinic. There are follow-ups at each clinic. Every case is reported on at three to twelve-month intervals, depending upon the nature of the case.

Our Record Librarian serves as part-time secretary to the clinic. She is in a position to know about all cancer admissions to the hospital and all pathologic reports on out-patients. She is responsible for the scheduling of new cases and the interval follow-ups. In follow-ups which are no longer in contact with the original referring physician, the County Medical Society has granted us the privilege of sending a card to the patient inquiring as to his present medical attendant and his general condition. When there is no response to the inquiry, the Public Health Nurse makes a visit. The local chapter of the American Cancer Society has sponsored the salary of a full-time nurse who works under the auspices of the County Health Board.

The Clinic Staff consists of a Chairman, who is Executive Director, a Pathologist and a Radiologist. These members serve at each clinic. However, the moderator, internists, surgeons and various specialists rotate at the clinic sessions, and the summary of each case is the composite opinion of all physicians present. We are fortunate enough to have on our staff consulting specialists from neighboring cities who attend our clinics regularly. We feel that we achieve a more cooperative spirit by having all staff members participate in the clinic's activities. The demonstration of pathologic specimens and the micro-projection of sections by the Pathologist has added a great deal of interest. In this way we have combined with our cancer clinic a clinical pathological conference in this particular field.

STATISTICS

(From July 18, 1947, to July 9, 1948)

Total Active and Associate Staff Members	34
Total Number of Doctors in Attendance at 25 Clinic Sessions	365

Submitted November 24, 1948.

The Authors

● Dr. Foster, New Philadelphia, Ohio, is a graduate of Western Reserve University School of Medicine, 1923; executive director, Tuscarawas County Cancer Clinic; and chief of surgery, Union Hospital, Dover, Ohio.

● Miss Yaberg, New Philadelphia, Ohio, is an active member of the American Association of Medical Record Librarians; secretary, Tuscarawas County Cancer Society; chief medical record librarian, Union Hospital; and secretary, Cancer Clinic.

Average Number of Doctors in Attendance Per Clinic Session	14.6		
Total Cases Seen in 25 Clinic Sessions	155		
Average Number of Cases Per Clinic	6.2		
Total Number of New Cases:	126	Average New Cases Per Clinic	5.04
Follow-Up Examinations:*	29	Average Follow-Up Per Clinic	1.2
Type of Cases:			
Proven Cancer	134		
Non-Malignant	21		
Males	68		
Females	87		

* We do not include follow-up reports on laboratory work, X-rays, etc., unless the case is presented.

CONCLUSIONS

1. The success of our clinic is attested to by the number of doctors in attendance and the number of cases referred. The medical group has developed a cancer awareness. Biopsies are done immediately on suspected lesions. The indication for and the limitations of the Papanicolaou test, the importance of biopsies and other diagnostic agents, and the accepted management of cancer are being correlated by all Staff members.

2. The public accepts the idea and requests their family physician to present them to the clinic for diagnosis and recommendations for treatment. Large civic-minded organizations pledge their support. We want for no equipment.

3. A cancer clinic in a small hospital will function successfully if personalities are avoided and the Staff of the hospital is given a prominent part in the discussion of cases.

Needs of Expectant Mother

From the start of pregnancy through each trimester and lactation, the expectant mother's body needs increasing amounts of proper food. Whether the expectant mother secures these extra foods depends on three principal factors: (1) her economic status, (2) her knowledge of food and the nutritional requirements for herself and the expectant newborn, and (3) the ability of her body to ingest, absorb, and utilize foods.

In the low economic group, failure of ingestion may be a result of both ignorance and economic status. The former is also common among the high economic group. Guerriero has recently completed a survey of 100 women entering pregnancy from a high economic group. In these it was noted that quality food intake was only about 25 per cent better than in a previously checked poor economic group. Unless there is judicious dietary regulation, some malnutrition will be present in nearly all pregnant women.—W. F. Guerriero, M. D., Dallas; Texas State Jrnl. of Medicine, Vol. 45, No. 5, May, 1949.

KEEPING UP WITH MEDICINE

• SHOCK treatment is beneficial for functional psychoses, but many patients so treated suffer a regression of their mental illnesses shortly after the treatment is completed

* * *

• FOR practical purposes, all neoplasms of the kidney are to be considered malignant.

* * *

• THE consensus is that the pain of angina pectoris is produced by myocardial ischemia.

* * *

• "THE problems of chronic disease and the aging population can be met only by the creation and utilizaton of abilities, rather than the building of facilities."

* * *

• WHEN a newborn baby has vomiting, rapid pulse, difficult breathing and cyanosis, congenital diaphragmatic hernia should be suspected. Here X-ray will do the trick.

* * *

• HEPATIC degeneration, prior to the establishment of fibrotic change is reversible.

* * *

• DESPITE their rarity in children, ureteral stones must be considered when there is pain, pus, and blood in the urine, or obstructive uropathy.

* * *

• THE habitual use of nosedrops leads to mucosal injury, destruction of the cilia and consequent impaired nasal function.

* * *

• THE higher incidence of tuberculosis among older people that mass X-raying is demonstrating, suggests that greater emphasis be placed on the older groups.

* * *

• THE expectant mother usually begins her pregnancy in a negative calcium balance.

* * *

• IF sodium intake is uncontrolled, from 250-300 ml. of water will be retained weekly during the last two months of pregnancy.

* * *

• DENDRITIC keratitis is due to a filtrable virus. Iodine therapy continues to be the best treatment.

* * *

• ALCOHOLIC beverages may be allowed the victim of gout if they do not precipitate an acute attack of arthritis.

* * *

• SALICYLATE poisoning may demand treatment for shock, acidosis, excitement, allergy (hives and/or asthma) or all four.—J. F.

A Case of Abdominal Pregnancy Secondary to Rupture Of a Rudimentary Uterine Cornu

STANLEY T. GARBER, M.D., and ROBERT W. KISTNER, M.D.

THE development of pregnancy in the interstitial portion of the fallopian tube or in a rudimentary horn results many times in obstetrical catastrophe. Te Linde,[1] in discussing the former site, states "this hemorrhage is apt to be much greater than that associated with the ordinary tubal pregnancy since the anastomosis of the uterine and ovarian vessels makes it one of the most vascular spots in the female pelvis." Stander[2] notes that "if the muscular tissue of the rudimentary horn is poorly developed, as is usually the case, spontaneous rupture occurs within the first four months and may lead to the death of the patient from intraperitoneal hemorrhage." About 100 cases of pregnancy in a rudimentary horn have been described. Mulsow[3] noted only nine cases reported since 1911.

The following case is of interest because of the benign course which followed the uterine rupture with extrusion of the fetus from its cornual site into the abdominal cavity with continuation of growth until the time of laparotomy.

CASE REPORT

A colored woman, Z. J., 29 years old, was admitted to the prenatal clinic of the Cincinnati General Hospital, April 28, 1948. Her last menstrual period was October 17, 1947. Chief complaints were vague lower abdominal pain, loss of weight, and vaginal bleeding of three days' duration. A previous episode of rather severe bleeding had occurred in January, 1948. It lasted five days and was associated with the passage of several large clots. Abdominal pain was present at that time also but lasted only a few days. It was described as dull and aching in nature. "Spotting" occurred again two weeks prior to the clinic visit. There had been a weight loss of seven pounds during the two weeks preceding admission. She had noted occasional anorexia, nausea and vomiting, and irregularity of bowel habit.

The family history was non-contributory. The patient's past history and review of systems were negative. The onset of menses was at the age of twelve years. The interval between cycles was twenty-eight days and the average duration was four to five days. She had had four previous pregnancies. Full term, spontaneous, normal deliveries occurred in 1932, 1937 and 1946. A spontaneous complete abortion of ten weeks' gestation took place in February of 1947.

The woman was well developed and well nourished. The temperature was 98.6 degrees F. The pulse rate was 92 and the blood pressure 120-78. She weighed 144½ pounds. The breasts showed changes typical of pregnancy. Abdominal examination revealed the presence of three separately discernible masses. A symmetrical, rounded, soft, boggy mass was palpable immediately above the symphysis pubis, extending to the level of the umbilicus. It was tender when moved. Another smaller, more firm mass was outlined just above the pubis, to the right and ventral to the former mass. A third, indefinite, somewhat elongated mass was palpable in the right upper abdominal quadrant, just below the costal margin. No fetal heart was audible and no fetal movement palpable.

Pelvic examination revealed a marital introitus with slight bluish discoloration of the mucous membrane. Skenes and Bartholin glands were negative. The cervix was soft, in normal position, and presented a few Nabothian cysts. There was no discharge from the external cervical os. Bimanual examination revealed the smaller mass to the right of the midline to be uterus with the larger, softer mass movable with it and seemingly attached to it.

The specific gravity of the urine was 1.016, the reaction was acid and tests for albumin, sugar and acetone were negative. The microscopic examination was likewise negative. Erythrocytes numbered 3,750,000 and leukocytes 12,000 per cubic millimeter of blood with 65 per cent neutrophils. The concentration of hemoglobin was 13 grams per 100 cc. of blood. The Kahn was strongly positive to standard and sensitized antigen.

X-ray examination (PA and lateral of the abdomen) revealed a very distinct image of a fetus in the right upper abdominal quadrant. There was no demonstrable uterine sac about the fetus and upon repeat X-ray examinations, it was noted that there was no change in the attitude or radio-opacity of the fetus. A separate mass was noted to rise out of the pelvis but did not approach the height of the fetal head. Hysterograms revealed the uterus to be slightly larger than normal size with twisting to the

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right. No connection was demonstrated with the larger mid-line mass.

On May 5, 1948, a laparotomy was performed. The preoperative diagnosis was abdominal pregnancy of about 5 months' duration. Pelvic examination under anesthesia corroborated previous findings. The larger, softer, mid-line mass was believed by some observers to represent placental mass, and by others to be a leiomyoma. Exploration revealed a small uterus, low on the right side and rotated further to the right. Coming from the region of the left cornu was a large, firm, round mass about six inches in diameter. Attached posteriorly near the apex of this mass was the left tube. On the right and posteriorly, extruding membrane was seen coming from a defect in this mass. Alongside of this defect was an obliterated umbilical cord which extended from this mass along the edge of the omentum toward the fetus which was found lying in the right upper quadrant. The fetus was dead and malformed, particularly the feet and head. Attached to the posterior aspect of the head was a loop of bowel.

The loop of bowel was dissected bluntly from the fetus and the latter removed. A supra-

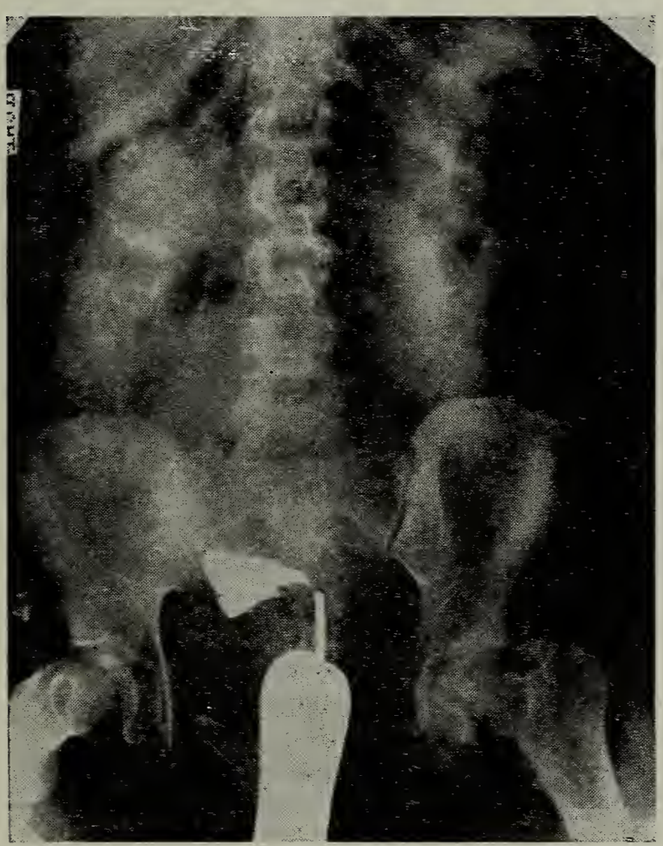


Figure 1. Unretouched photograph of the hysterogram showing the uterus rotated to the right and a five months' fetus lying in the right upper quadrant.

vaginal hysterectomy and left salpingo-oophorectomy was done and the abdomen closed in layers.

Pathological report: "Gross specimen consists of the uterus, fetus, one tube and ovary. The uterus measures approximately 10 cm. in length and is greatly thickened and edematous. Emerging from one horn is a large, soft mass which is approximately 12 cm. in diameter. It is completely occupied by placenta in its internal portion. The capsule enclosing the placenta is thinned out to about ¼ to ½ cm. in thickness in some areas. Attached to the uterus on the opposite side is a relatively normal tube and ovary. There appears to be a direct communication between the uterus and the large aberrant mass in the cornu. Separately submitted is a 20 cm. fetus."

Microscopically, sections from representative areas show placental tissue closely overlying

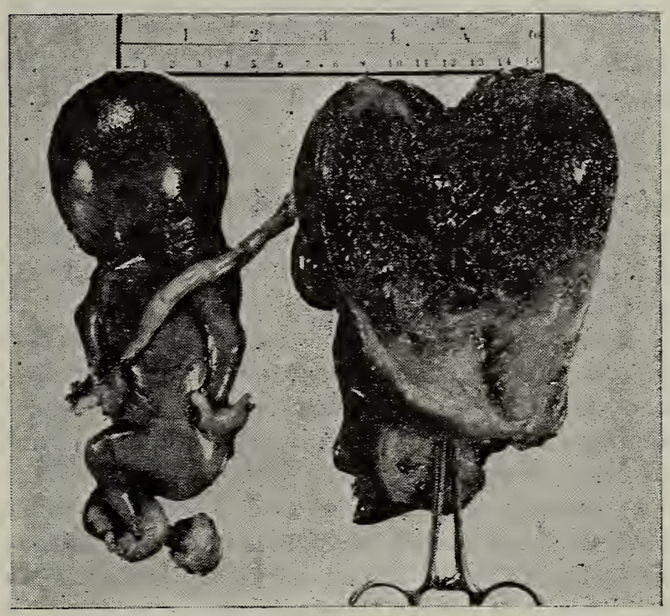


Figure 2. Photograph of the removed specimen with the uterine cornu opened to show placenta filling the entire horn. A clamp has been inserted through the cavum uteri into the small opening in the involved horn.

myometrial tissue. This section was taken at the junction of the mass and uterus.

It is believed, therefore, that implantation occurred in the cornual portion of the uterus, rupturing about the third or fourth month with extrusion of the fetus and retention of the placenta in the cornu. Hemorrhage was minimal or well controlled by walling off, although no adhesions were discovered at operation. Following rupture into the abdominal cavity, the fetus continued to live for approximately a two month period.

The postoperative course was uneventful, a temperature of 100.8 degrees F. on the first postoperative day being the only elevation. The patient was discharged on her thirteenth day. Postpartum examination six weeks later was essentially negative.

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Thirty-three cases of cystic disease of the lungs have been seen at Duke Hospital from 1943 through 1948. Nine of these cases are reported, in an effort to emphasize the protean manifestations of this disease, and to illustrate how easily the symptoms and signs may stimulate the more common pulmonary diseases and hence cause an erroneous diagnosis.—E. E. Menefee, Jr., M. D., North Carolina Medical Journal, April, 1949.

Epidural Spinal Abscess

CHARLES W. ELKINS, M.D., and DREW J. ARNOLD, M.D.

THE purpose of this paper is to present six cases of epidural spinal abscess seen at Cleveland City Hospital since 1938. These cases were all pyogenic in origin and we have not included those cases of spinal epidural abscess secondary to spinal tuberculosis.

Grant[1] states that there are over two hundred cases of this disease reported in the literature but its relative infrequency is demonstrated by the small number of cases in each individual series.

Several collected series have been reported. Mixter and Smithwick[2] reported ten cases, Browder and Meyers[3] fourteen cases, and Grant[1] fourteen cases, which represent the largest individual series.

According to Hirschfield and Yoskin,[4] the disease was recognized as early as 1820 by Bergamaschi[5] in Italy. Many surgical textbooks do not mention epidural spinal abscess and it is probable that the disease is not so rare as is its recognition and proper treatment.

The incidence of epidural spinal abscess is unknown. Dandy[6] in 1926 reviewed the literature of twenty-five recorded cases and reported that he had seen no patients with the disease.

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LOCATION AND ETIOLOGY

Epidural spinal abscess is an infection which involves that space lying outside the dural canal. The space lies posterior and posterior lateral to the canal and is formed by the separation of the dura mater as it leaves the foramen magnum. It extends caudad in the vertebral canal until the caudal sac is reached in the sacral region. The boundaries of the epidural space are the periosteum of the laminae and vertebral bodies externally, and the dura mater internally. On the anterior surface and in the cervical region the space is but potential because of the close adherence of the dura mater to the periosteum of the vertebral bodies. The space contains areolar tissue and numerous blood vessels. It probably serves as a cushion to prevent torsion of the spinal cord and nerve roots due to sudden movement of the spinal column. The size of the epidural space varies inversely with the size of the spinal cord. At the level of thoracic four to thoracic eight, it assumes a depth of 0.5 to 0.75 cm., narrows as it progresses downward and then widens to attain its greatest depth over the lower lumbar and upper sacral regions.

Thus the most frequent sites of epidural spinal abscess are in those areas of greatest depth, the middorsal and lumbar regions. The abscesses are most usually located posterior to the dural canal. According to Echols[7] there are reported only five cases of abscess situated anterior to the dural canal.

Staphylococcus is the usual etiological agent, although cases secondary to streptococcus, pneumococcus, pyocyaneus and other organisms have been reported. Stammers[8] describes the modes of infection as follows: by direct extension from infected wounds, osteomyelitis of vertebral bodies, retropharyngeal, perinephritic or posterior pharyngeal abscesses; by introduction of infection secondary to faulty lumbar puncture technic; or by a hematogenous or metastatic route from antecedent furuncles, boils, otitis media, sinusitis and many other infections. Of eighty-eight cases collected and analyzed by Browder and Meyers,[14] fifty-nine were due to staphylococcus and thirty-five of these had histories of antecedent furuncles. A history of trauma to the spine is present in a large number of cases.

There is some disagreement as to whether epidural infection occurs most frequently as a primary metastatic lesion or whether it is secondary in nature to osteomyelitis of a vertebra. Most writers admit to the frequency of both methods, but Browder and Meyers[3, 14] maintain all such lesions are preceded by vertebral osteomyelitis, and Hunt[9] says osteomyelitis is a constant finding. The excruciating boring back pain experienced by most patients with this disease may well be conclusive of such a viewpoint.

PATHOLOGY

An epidural abscess may be acute, with free pus, or subacute with free pus and dural granulation, or chronic, with a solid extradural fibrous mass or granuloma without definite macroscopic

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evidence of infection. Acute and subacute abscesses are probably indistinguishable clinically, but chronic epidural granulomas clinically have insidious onsets and are hard to distinguish from spinal cord or cauda equina tumors.

The accompanying pathology usually finds the dura thickened and reddened, the ligamentum flavum friable and the bone quite soft. The epidural fat is hard and bleeds easily and in granulomas may be necrotic and very adherent to the dura. Pus may extend the entire length of the epidural space, may loculate, or gravitate down to the lumbar region from higher up.

It is a well known fact that the spinal cord cannot tolerate rapidly increasing pressure, and the nature of the mechanism of cord block and its neurological manifestations has been a topic of much interest and discussion. It may be possible for the abscess itself to create enough pressure to block the canal and create pressure on the cord sufficient to produce the manifestations of myelitis, but this idea is not wholly accepted. Histologic changes noted in the cord have been out of proportion to the pressure of the abscess. There is concomitant thrombosis of spinal vessels which destroys or impairs the vascular supply to the cord,[10, 11, 14] and this itself may produce enough relative avascularity to cause a softening of the cord and transverse myelitis. Axonal degeneration and areas of rarefaction and vacuoles are seen in cases with marked irreversible changes and the degree of residual paralysis, if any, after treatment depends upon the degree of these irreversible changes.

Pus may occasionally extend through the intervertebral foramina into the thoracic cavity or perinephric tissues, or may extend between the laminae of the spines to the fascia and muscles of the back.

DIAGNOSIS

One is impressed by the similarity of the reported cases of epidural abscess in the literature with regard to the onset of the illness and its course. There is usually a history of infection of some nature as previously described, most often a boil or furuncle, in a patient of the younger age group. Trauma to the back may be a precipitating factor. A short time later there develops the gradual or sudden onset of back pain. Boharas and Koskoff[12] state that the interval between the history of infection or trauma to the spine until the onset of back pain varied from one day to three years in a collected series of eighty-five cases, with the average time being four and one-fifth weeks. As the pain persists and becomes more severe, the clinical signs of infection, fever, toxicity and localized tenderness develop. It is fortunate that the patient has severe enough pain that he seeks professional advice early. The pain is very annoying, constant, at times throbbing, and is made worse by coughing, sneezing or motion of the spine.[3] According to Dandy[6] the pain caused by epidural space infection is more severe and persistent than in any other proved spinal lesions. Radicular pain is very common and pain may thus be referred to the arms, thorax or abdomen. Pleurisy, gastric crises, acute abdomen and peripheral neuritis may be simulated.

Following the onset of pain by an interval of five to twenty days, there occur various neurological changes which are progressive in nature. A stiff neck and positive Kernig and Brudzinski's signs occur early. There is then gradual motor involvement beginning in the legs with paresis or paralysis. The paralysis is usually flaccid in nature but may be spastic, and the reflexes are absent or hypoactive. Loss of bladder and rectal sphincter control is invariably present. While often less pronounced than motor involvement, sensory changes may appear early and be progressive. There may be a gradual onset of numbness and paresthesia in the lower extremities leading to a sensory level of anesthesia which may serve as an excellent indication of the location of the lesion. One sign characteristic of an abscess is a definitely rising level of girdle pain or sensory disturbance. Fever and leukocytosis are present, and there may be localized edema over the tender area.

Lumbar puncture gives extremely valuable information as to the diagnosis, but must be done with great care. If an epidural abscess is present in the lumbar area, infection can readily be carried through the dura into the subarachnoid space by the needle, thus leading to meningitis. In cases of suspected lumbar abscesses, aspiration should be attempted at frequent short intervals as the needle is pushed through the tissues towards the spinal canal. If pus is obtained, the subarachnoid space should not be entered.

The usual finding upon lumbar puncture is a spinal subarachnoid block, partial or complete. In some cases this may be demonstrated before the clinical signs of cord compression are present.[13] The spinal fluid may be clear, cloudy, hemorrhagic or purulent, but it is most often xanthochromic, clots spontaneously and has a pleocytosis. A normal cell count may be obtained however. A Froin syndrome, or xanthochromic spinal fluid with dynamic block, may be demonstrated. The total protein content of the spinal fluid is invariably elevated and may run as high as 1800 mg. per cent or more. If

cells are found they are usually mononuclear white cells.

We feel that the diagnosis of an epidural spinal abscess should be comparatively easy if one keeps it in mind as a possibility. The presence of pain in the back following an antecedent infection or trauma and accompanied by tenderness over the vertebral spines; signs of ascending motor and sensory abnormalities and the presence of a subarachnoid block with a xanthochromic spinal fluid with increased protein and cell count makes the diagnosis of epidural abscess mandatory until proven otherwise. The careful aspiration of pus from the epidural space may prove the diagnosis preoperatively.

The differential diagnosis of this disease is usually not difficult. Acute poliomyelitis and meningitis have different neurological and spinal fluid findings. Acute infectious myelitis may simulate spinal epidural abscess, but there is usually no subarachnoid block as determined by lumbar puncture. Spinal cord and cauda equina tumors have a more insidious onset. Characteristic X-ray changes in the vertebral column serve to differentiate Pott's disease.

TREATMENT

Once the diagnosis of epidural spinal abscess has been made the treatment is immediate laminectomy and drainage of the abscess. Complete or nearly complete recovery of the patient may be expected if this is performed early enough, but once paralysis and sensory changes have been present over twenty-four to seventy-two hours there is probably little chance of recovery.

The level of the lesion and thus the level of laminectomy is determined by the sensory level attained, the level of the back and radicular pain and by the location of the tenderness of the vertebral spines on palpation. Myelograms using a radio-opaque media may be done to define the extent of the block. Wide drainage should be established, removing as many laminae as is indicated. The epidural space should be irrigated with a small catheter and after the relief of pressure caused by the pus the cord will be seen to pulsate. The wound may be packed entirely open or partially closed after drains have been placed along the epidural space. The wound will granulate in gradually and may be closed secondarily. Tidal drainage, intravenous fluids and penicillin are all important adjuncts to the postoperative management.

The mortality rate in our series of six cases was fifty per cent, which is fairly representative of the literature. In 69 cases analyzed by Browder and Meyers,[3, 14] they report 18 as having died and 51 recovered with a mortality of twenty-six per cent. Function was recovered in 38 of these 51 cases. Boharas and Koskoff[12] review 103 reported cases; an early diagnosis was made in five cases only and 33 cases were diagnosed at autopsy; 64 cases were diagnosed after the onset of paralysis and of these 37 died, twelve recovered with paresis and 15 recovered completely. Death is usually due to pyemia, pyelonephritis, bronchopneumonia and meningitis. Those patients who have incomplete recoveries may show a varying degree of residual neurological changes.

REVIEW OF CASES

Six cases of epidural spinal abscess, five acute and one subacute, were diagnosed at Cleveland City Hospital from 1938 to 1947. One of these was an autopsy diagnosis and no neurological lesion was suspected antemortem. The other five cases had laminectomies and of these two died and three had excellent recoveries. It is interesting to note that the three deaths occurred in the first three cases observed.

The age incidence of our patients, four males and two females, varied from 16 to 59 years, with an average of 30.7 years. A history of primary infection was present in all but two of the cases and those were males who had jobs involving heavy lifting, one giving a definite history of back injury. Furuncles, cellulitis and sinusitis were the types of infection, and one of these patients had an acute vegetative mitral endocarditis.

In every case it was noted that pain in the back was the first symptom complained of and in every case there was definite tenderness of the spine overlying the abscess. No definite statement can be made regarding the time interval between the primary infection or injury and the onset of symptoms except to say that it varied from a few days to three weeks. In four of our cases flaccid paresis involving the legs was the initial neurological sign and this was usually accompanied by retention of urine.

The predominant neurological findings were interesting to note. All six patients had paralyzed bladders. Three patients had complete paralysis and well-defined sensory levels. One patient had marked paresis of the legs and spotty sensory changes but no definite sensory level. One patient had marked paresis of both arms. Another patient, with a subacute abscess and who had a nearly complete recovery following laminectomy and drainage, complained of tingling and paresthesias of the legs but never demonstrated any motor involvement. The patient whose epidural abscess was diagnosed at autopsy had apparently no sensory or motor abnormalities but had a marked hyporeflexia. Hyporeflexia or areflexia was common with the other patients.

Fever was almost invariably high and leukocytosis was present in all but one case.

X-rays of the vertebrae were negative in the five cases in which they were taken, but it is interesting to find that in the two cases in which autopsies were obtained there was demonstrated osteomyelitis of the vertebrae, thus indicating again that osteomyelitis is probably present much oftener than recognized.

Lumbar puncture in four of five cases revealed the typical findings of xanthochromic spinal fluid, increased total protein and subarachnoid block. A lumbar puncture was not performed in the case diagnosed at autopsy. Protein levels went as high as 1800 mg. per cent. In one case, pus was aspirated from the epidural space.

The average length of time between the initial neurological signs and operation was seven days. Laminectomy was performed in five patients. Two cases had high thoracic lesions, two low thoracic lesions and one patient underwent operation for lesions both in the lumbar and mid-thoracic areas. The laminectomy wounds were all either packed open or partially closed with drainage of the epidural space. Hemolytic Staphylococcus Aureus was the causative organism in four cases and streptococcus viridans in the fifth case.

Recovery from this disease following operation was very dramatic in the three successfully treated cases. Loss of back pain occurred very soon. There was a return first of bladder control in two patients and in motor power in the other patient. Day to day improvement was noticed in all patients. One wound was closed secondarily and the other two were left to granulate. The average postoperative hospital stay of these three patients was forty-three days, and they were discharged ambulatory with their wounds healed and with slight, if any, residual sensory or motor changes. One patient has now been followed three and a half years, is working regularly and complains of only occasional pain in the operative scar. Another patient has been followed over one and a half years, works regularly as a roofer and complains occasionally of hyperesthesia on the outer aspect of his right leg and foot and occasional weakness in the back. The third patient has been followed three months, and has returned to work. He has no complaints and an examination demonstrates only a diminished ankle jerk on the right.

The three patients who died, succumbed to fulminating infections and other complicating factors. The first case, whose epidural abscess was diagnosed at autopsy, had Laennec's cirrhosis, jaundice, and died in uremia with pyemia and multiple abscesses. The second patient had several laminectomies for drainage of epidural infection in the lumbar and thoracic regions and showed no improvement at any time. The third patient, never improved following laminectomy and died of acute vegetative mitral endocarditis with septic emboli and multiple metastatic abscesses.

SUMMARY

A discussion of spinal epidural abscess secondary to pyogenic infection has been presented.

Commonly a history of antecedent infection followed by localized back pain and onset of increasing neurological symptoms is obtained from the patient.

Typical lumbar puncture findings are xanthochromic spinal fluid with high protein content, and spinal subarachnoid block as determined by the Queckenstedt test.

Aspiration of the epidural space at the level of the suspected lesion may establish the diagnosis if pus is obtained.

Early laminectomy with drainage of pus offers hope for recovery of function.

Experiences with six cases of pyogenic epidural abscess have been presented.

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To summarize, sixteen cases (of chronic brucellosis) were treated (with sodium bismuth tartrate), twelve of which had complete remission of symptoms, two had some amelioration of symptoms, and two were not benefited. These cases, however, had only been clinically observed for a period of twelve months; therefore, future prognosis using this type of therapy must be guarded until further study of these cases and others can be effected.—W. L. Wissman, M. D., and T. D. Carpenter, M. D., Journal of the Indiana State Medical Association, May, 1949.

Fat Necrosis of Omentum With Perforated Duodenal Ulcer*

A. E. RHODEN, M. D.

THE small, white and opaque foci of fat necrosis are most characteristic in appearance. These lesions are usually recognized at a glance as soon as the peritoneal cavity has been opened. They are generally thought to be pathognomonic of pancreatic necrosis by surgeons and pathologists alike. Typical of this concept is Boyd's statement: "Fat necrosis always indicates a coexistent pancreatic necrosis. . . ."[1]

The preferred present-day treatment of acute pancreatitis (pancreatic necrosis) appears to be non-surgical.[2] A surgeon, exploring an acute abdomen and noticing fat necrosis, is apt to conclude that he is certain to be dealing with pancreatic fat necrosis. He may therefore close the abdomen immediately, without any further investigation.

Typical fat necrosis may, however, occur with perforated duodenal ulcer as shown subsequently. The purpose of this report is therefore to make the surgeon aware of this possibility so that he will inspect the duodenum routinely in the presence of fat necrosis. He will then be able to perform life-saving closure of perforated ulcers whenever these are the cause of the fat necrosis.

CASE REPORT

(Flower Hospital, A 51-48) A 74-year-old white male was suddenly seized with severe pain in the epigastrium and lower chest. He was treated at home for three days. He developed diffuse abdominal tenderness and was moribund upon admission to the hospital.

Autopsy findings: (Only the pertinent ones are given.) The peritoneal cavity contained some discolored fluid. The omentum in the epigastric area showed numerous small, white and opaque lesions characteristic of fat necrosis.

The first portion of the duodenum showed a perforation in its anterior wall which measured 3 mm. across. Bile-stained fluid escaped from this opening. The perforation had occurred in the base of a peptic ulcer which was small but deep. The fat necroses were most numerous in the vicinity of the perforation. They were almost exclusively located upon the greater omentum. In microscopic sections, the changes of fat necrosis were seen to be situated directly beneath the peritoneal lining.

The pancreas appeared normal grossly and showed a normal histological appearance in numerous blocks taken from different areas.

DISCUSSION

Fat necrosis of this type is caused by the lipase of the pancreas. With pancreatic necrosis, the lipase is apparently transmitted through lymph channels.[3] However, fat necrosis has been produced experimentally in animals by the intraperitoneal injection of pancreatic extract.[4] The mechanism of the fat necrosis in the present case is apparently a comparable one since pancreatic juice reached the peritoneal cavity through the perforation in the duodenum. This accounts for the fact that the fat necroses were found to be most numerous in the vicinity of the perforation and that they were situated superficially in the omentum, directly beneath the peritoneal lining.



Figure 1. The perforation in the duodenum is seen, together with the scattered areas of fat necrosis in the omentum. Note: Dr. T. Zbinden took the photograph which is gratefully acknowledged.

SUMMARY

A case of perforated duodenal ulcer is reported where pancreatic juice escaped through the perforation and caused fat necrosis in the adjacent omentum. It is important for surgeons to realize that omental fat necrosis need not always be caused by pancreatic necrosis. An exploration of the duodenum is indicated when fat necrosis is seen.

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Hyperinsulinism Caused by Islet Cell Adenoma; Review of the Literature and Report of a Successful Surgical Case

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ALTHOUGH characterized by low blood sugar, hyperinsulinism is not synonymous with hypoglycemia, a symptom which may exist independently as a result of adrenal insufficiency, pituitary tumor, extensive disease of the liver or of the muscles, changes in the thyroid secretion, or any one of several other conditions. Clyne[10] lists seventeen possible causes.

Hyperinsulinism may be caused by the administration of excessive amounts of insulin, by hypertrophy and hyperplasia of the islands of Langerhans, or by neoplasms of the islet cells. Some authors would restrict use of the term to the syndrome caused by the latter condition, referring to hyperinsulinism of any other etiology as "functional hypoglycemia." In this paper we are concerned only with cases of hyperinsulinism arising from tumors of the islet cells, benign adenomas in particular, and our use of the term will imply the existence of a neoplasm.

HISTORICAL SURVEY

Less than a quarter of a century has passed since hyperinsulinism was first recognized as a clinical entity. In 1924 Seale Harris[22] reported a series of twelve patients whose blood sugar values were less than 70 mgs. per 100 cc. of blood, and revealed no other pathology to account for episodes of lassitude and mental confusion, severe hunger and weakness. Harris concluded that spontaneous insulinism was the probable cause. Three years later Wilder, et al.,[43] reported the first clinical case of hyperinsulinism caused by an islet cell tumor and were able to demonstrate a functioning neoplasm; unfortunately the tumor had metastasized to the liver and the patient lived only a few weeks after surgery. In 1929 Howland, et al.,[24] reported that Roscoe Graham had achieved the first surgical cure of hyperinsulinism caused by a neoplasm of the islet cells; the patient was completely relieved of symptoms after removal of what was then thought to be a slow-growing carcinoma of the islet cells, but in view of more recent evidence was probably a benign growth.

In 1933, Graham and Womack[19] reviewed the literature and added cases of their own, bringing the total to seven successfully treated surgical cases, with no reported mortality. Soon Whipple and Frantz,[41] who have operated on perhaps the largest series of cases, presented the first of three reports, together with a painstaking survey of the literature. Other reviews of the literature, with additional case reports, have been published by Keating and Wilder,[27] by Cline,[10] by Walker and Boger,[39] and most recently by Lopez-Kruger and Dockerty.[30] The latter found 112 successfully treated cases, including his own, up to January, 1945. We have found reports of 18 other successful surgical cases published since that date. Allan and Marshall[2] reported four, Isaacs,[26] Maxeiner and Bundy,[33] Bishton and Maline,[4] Nordland,[34] Clyne, et al.,[10] Carpenter,[9] Holmes, et al.,[23] each reported one, Marble reported five, and Walker and Boger reported two previously unpublished cases. We are also able to add a case of our own, thus bringing the present total of surgical cures to 131.

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INCIDENCE

In any case of suspected hyperinsulinism it is first necessary to rule out the non-pancreatic causes of hypoglycemia. On the other hand, tumor of the islet cell does not necessarily give rise to hyperinsulinism. It is generally conceded that the great majority of recorded cases have been recognized at autopsy as purely incidental findings,[5, 10, 14] and that only about 20 per cent are functioning neoplasms.

Estimates of total incidence have varied widely. Winters[44] found no islet cell adenomas in a review of 13,000 autopsy records, but many authors accept Pappenheimer's[35] frequently quoted ratio of 1 to 800 or 1 to 1,000 autopsies, generally agreeing that only about 20 per cent of these give rise to symptoms of hyperinsulinism. More recently Lopez-Kruger,[30] by serial section of the pancreas, found 44 adenomas in 10,314 autopsies. In this series 36 were non-functioning and only 8 were functioning. These figures tend to

preserve the previously accepted proportion of functioning to non-functioning tumors, but indicate a much higher incidence of both types than had been mentioned previously. Kerwin,[29] among others, had already expressed the belief that the incidence of adenoma of the islands of Langerhans is much greater than is usually recognized.

Clyne[10] pointed out that any estimates as to incidence are likely to be misleading because many adenomas are of microscopic size, exceedingly difficult to find even when the object of careful search. Therefore, it is obvious that in routine autopsies gross sectioning must fail to disclose any but the occasional adenoma. Considerable weight must be given, then, to the figures indicated by Lopez-Kruger's study.

It has been said that this syndrome may exist at any age,[15] but it is commonly agreed that the majority of reported cases have appeared in the 30 to 50 age bracket. In the Mayo Clinic series of 22 cases reported by Lopez-Kruger[30] the age of the patients ranged from 9½ to 68 years, but the average was 41½ years. In a search of the literature Clyne[10] found record of a patient 7 years old. Sherman[38] recorded the fatal case of a newborn who displayed symptoms from the age of 24 hours onward; surgery at the age of 14 days revealed a very small tumor, which was not excised, and when the child died at the age of 6 weeks an autopsy confirmed the existence of an adenoma. Walker and Boger[39] ventured the opinion that their patient, age 67, was one of the oldest on record to recover.

SYMPTOMS AND THEIR DURATION

The symptoms are essentially those of an insulin reaction; but because they are myriad in number and various in form, because they simulate half a dozen better known conditions, and because their onset is likely to be insidious and their manifestations intermittent, their recognition offers a challenge to the diagnostician. Hyman[25] lists six stages of the accompanying hypoglycemia. These range from the premonitory, which is characterized by fatigue and malaise, through the epinephrine stage (indicated by fear, palpitation, tremor, hunger, and thirst), the intoxication stage, the paralytic stage, and coma, to death.

Thus it becomes apparent that the first indications of a functioning adenoma may easily be attributed to some other condition or else ignored altogether. The occasional attacks of drowsiness, weakness, fainting, diplopia, unusual hunger, thickness of speech, or brief mental confusion may be ascribed to some other temporary condition and quickly forgotten. The attacks then increase in frequency and severity, progressing through periods of increasing stupor or unconsciousness, automatism, and personality changes, to coma and convulsions within the space of three to five years, on the average.

We appreciate the fallacy of attempting to find an average in a disease presenting such bizarre manifestations, and hasten to explain that in a review of 29 case histories which explicitly state the duration of symptoms in successfully treated patients, the average duration was five years; the shortest was fourteen weeks, the longest thirty-eight years, and the mean was three years. One case, described by Walker and Boger,[39] advanced from mild episodes of sleepiness, diplopia, and irritability to maniacal outbursts strongly suggestive of brain tumor—all in the space of fourteen weeks. On the other hand, a case history reported by Wilder[42] mentions episodes of weakness, thickness of speech, and abnormal nervousness occurring over a period of thirty-eight years prior to an attack severe enough to cause total loss of consciousness. It may or may not be significant that the latter patient associated epigastric pain with his attacks from the beginning. Both Wilder[42] and Carpenter[9] remark upon the frequency of such association.

The episodic nature of the clinical symptoms is generally considered characteristic, but Malamud and Grosh[31] reported a fatal case in which the symptoms were unremitting during the last two years of life. In that instance the patient died six years after the first attack. Kerwin[29] reported an adenoma which caused death sixteen days after the onset of symptoms; the last eight days of life were spent in continuous coma. The pathological diagnosis in both instances was "benign adenoma."

Wilder,[42] a frequently-quoted authority, classified the symptoms into three general groups:

(1) Disturbances of the vegetative nervous system.
(2) Organic neurologic symptoms.
(3) Psychopathological manifestations.

Symptoms are usually experienced before meals, and most authors remark upon the "dramatic" relief provided by the ingestion of sugar. It is usually accepted that prompt relief of symptoms following administration of glucose constitutes an acceptable criterion of islet cell tumor. However, in the fatal case reported by Kerwin[29] a tentative diagnosis of adenoma was discarded because there was no remission of symptoms upon administration of glucose. But in most instances the patient himself discovers that eating, particularly sweets, will prevent, or at least minimize, an incipient attack; such a statement in the patient's history is exceedingly helpful to the diagnostician. On the other hand, some patients fail to discover the value of sugar in aborting an attack.[28, 39]

The foregoing discussion may serve to illustrate the multiplicity and diversity of symptoms presented by this condition and to explain why the diagnosis has so frequently been delayed, obscured, or missed altogether.

CLINICAL DIAGNOSIS

The early symptoms, weakness, mental confusion, hunger, pallor, sweating, trembling, and emotional instability occurring singly or in any of an infinite variety of combinations, have frequently been mistaken for hysteria or neurasthenia.[9, 10, 26] Later manifestations, such as mental confusion resembling alcoholic intoxication, pronounced personality changes, convulsions and coma, have frequently led to an erroneous diagnosis of epilepsy or brain tumor.[9, 10, 33, 39] Between these two extremes the varied manifestations of disturbed carbohydrate metabolism may be mistaken for any one of several other conditions, toxic goiter[34] and peptic ulcer[42] among them.

Even when hypoglycemia is recognized there is considerable danger of mistaking its cause. As previously stated, there are many possible reasons for a state of hypoglycemia, and some of them are remote from surgical control. Nervous instability may cause temporary hypoglycemia, and Conn[12] stated that the fasting blood sugar level of even a normal person may fall to 46.

Many authorities consider that the prolonged fast is the most important single criterion in distinguishing true hyperinsulinism from functional hypoglycemia.[2, 18, 42] It is asserted that even mild cases of the former present characteristic symptoms of progressive insulin shock after a fast of twenty hours, while persons suffering from purely functional hypoglycemia are able to continue a fast beyond that limit with only transitory discomfort.[2] However, Kepler[28] reported a proved case of adenoma in which mild, non-disabling symptoms were induced only after a fast of 23 hours, though the blood sugar value fell to 35 mgs. per 100 cc. On the other hand it has been demonstrated that fasting blood sugar may be within or above normal limits in isolated instances of adenoma.[1]

Some workers have remarked that there is seemingly little relationship between level of blood sugar and appearance of symptoms, since the blood sugar level present during one attack may appear earlier or later in the same patient without producing symptoms.[13, 39] Malamud and Grosh[31] noted that there was no alteration of clinical symptoms in their patient when blood sugar was kept within or near normal limits by dietary measures.

Aitken[1] regarded low blood sugar during a seizure, with immediate relief following ingestion of carbohydrate, as adequate evidence of hyperinsulinism.

Clyne[10] cited Greenlee and others who independently expressed the opinion that no known diagnostic procedure short of exploratory laparotomy can definitely prove that any given case of hyperinsulinism is caused by a tumor of the islands of Langerhans. However, he considered the insulin tolerance test and the patient's reaction to epinephrine helpful diagnostic measures. In contrast, both Malamud[31] and Walker[39] mentioned that they found the epinephrine test unsatisfactory in their respective cases.

Opinions differ as to the value of a test of carbohydrate tolerance. One would expect to find it increased, with the peak level possibly at 100 mgs. per 100 cc. or thereabouts, in contrast to a normal elevation to approximately 200 following the test.[11] Some authorities consider this test a valuable procedure, but only to confirm other evidence[1]; others believe that the test is useful only if continued for at least four to six hours.[25, 32] Conn and Conn[13] expressed the opinion that the test would be considerably more useful if a standard preparatory diet were used, since the previous diet greatly influences the type of curve produced. Malamud and Grosh[31] analyzed the dextrose tolerance curves reported in the literature and concluded that the type of curve indicates the severity of the disorder, but found no one type characteristic of adenoma.

Whipple formulated a triad which is frequently quoted as a basis of differential diagnosis:[33]

(1) Attacks of insulin shock during fasting or following over-exertion.

(2) Blood sugar of 50 mgs. or less per 100 cc. during an attack.

(3) Prompt relief of symptoms following ingestion of glucose.

Conn's[12] triad differs only slightly. Wilder[42] postulated a history of normal health and nervous stability prior to the first attack as essential in distinguishing true hyperinsulinism from functional hypoglycemia. He also emphasized the importance of signs of brain involvement; he enumerated headache, parathesis, diplopia, disorientation, and amnesia, and regarded the last named as a particularly important indicator of adenoma.

There have been enough exceptions to each of these criteria, in proved cases of adenoma, to demonstrate the complexity and the bizarreness of the syndrome, and the fallacy of depending upon any one criterion for diagnosis. There is need for careful and detailed study of the patient's history, and equal need for a period of close observation of the patient; this is particularly true if he manifests any psy-

chotic symptoms, whether or not they are accompanied by overt indications of hypoglycemia.

SURGICAL DIAGNOSIS

Recognized adenomas have varied in size from the non-functioning microscopic growth to the functioning tumor of grapefruit size reported by Aitken.[1] The average size of functioning adenomas reported in the literature is 1.5 cm. diameter,[4] and only rarely is one found larger than 2 cm.[11] At the other extreme, Lopez-Kruger[30] reported functioning adenomas of 2.5 mm. and 4 mm., respectively, in the same patient. He believed those to be the smallest of their kind on record, since adenomas of less than 5 mm. usually are sub-clinical.

The pinkish blue color of the growth is frequently said to be typical, but there have also been reports which remarked upon their yellowish cast. Aitken[1] explains that the smaller ones gain their purplish color from their high degree of vascularity, while the larger ones contain areas of necrosis which lend the yellow tinge.

At one time it was believed that encapsulation was an essential characteristic of the benign tumor.[40] Since then many such neoplasms have been found with little or no capsule. On the other hand, Bishton[4] cites a case in which an islet cell malignancy was encapsulated. Therefore, the presence or absence of a capsule is no longer regarded as a criterion of either benignity or malignancy.

Good[17] has advanced an interesting theory to account for the inconsistency of encapsulation. He suggested that the wall of a pancreatic duct and the wall of the capsule are one and the same. Therefore, the presence or the absence of a capsule would depend only upon whether the adenoma originated in a duct with or without a wall.

PATHOLOGICAL DIAGNOSIS

Various stains are used for microscopic identification. Histologically the arrangement of the cells resembles that of the islands of Langerhans.[16, 40] However, the histological appearance of malignancy has not always proved true.[6, 9, 15a, 21] Adenomas suspected of malignancy by the pathologist have been removed at operation with the result that the patients have survived from five to ten years without recurrence of symptoms.[15a] Some workers now consider an islet cell tumor benign unless there is evidence of invasive action.

Walker and Boger[39] advanced a tentative theory as to the possible origin of the adenoma. They suggested that in a diabetic a supreme effort may be made by the anterior lobe of the pituitary gland to stimulate the production of insulin, and that in some instances certain tissues of the islands of Langerhans respond in excess, thus giving rise to a neoplasm. They added that should this theory be correct then surgical removal of an islet cell adenoma could result in the emergence of a diabetic state which had previously been masked by the insulin-production of the neoplasm. In support of this hypothesis they pointed to the frequency with which a diabetic type of sugar tolerance curve is reported during the immediate postoperative period in adenoma patients. In this connection it is interesting to note that Wilder[42] has cited a case

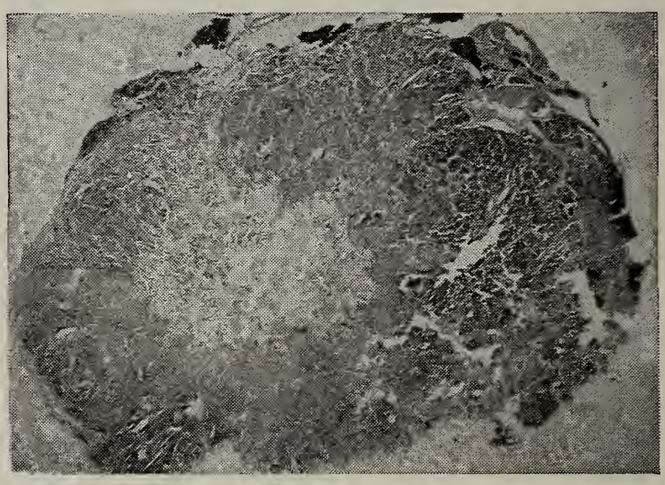


Figure 1. Section of adenoma, low power magnification.

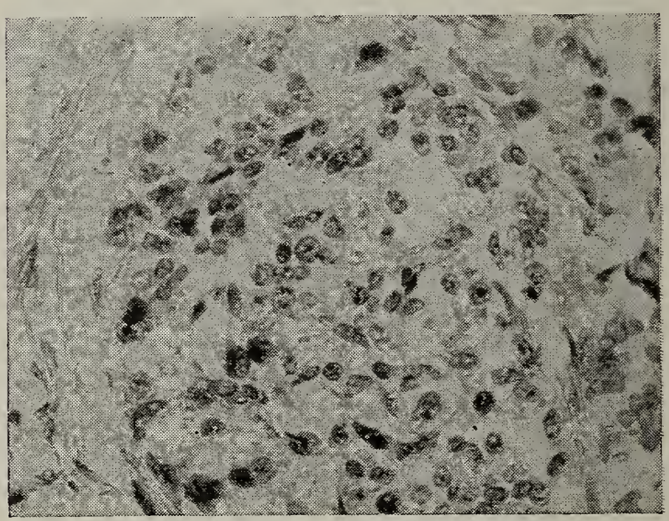


Figure 2. Section of adenoma, high power magnification.

reported by Bickel, et al., in which a diabetic condition gave way to hyperinsulinism and cancer of the islet cell, with metastasis, was found at autopsy.

ASSOCIATED PATHOLOGICAL CONDITIONS

A reasonable search of the literature has revealed three cases in which proved adenoma of the islands of Langerhans has existed simultaneously with adenoma of the thyroid.[15, 20, 31] Two of these were fatal, but only one of the two received surgical treatment. Two other patients had proved adenomas of the islet cell with symptoms of goiter;[1, 34] one of these received X-ray treatments and the other had thyroidectomy, but neither experienced remission of

symptoms until after excision of the islet cell adenoma. It is interesting to note that the patient whose thyroid was removed had milder attacks of hypoglycemia during the period of greatest thyrotoxicosis, and developed hypothyroidism following resection of the islet cell tumor.

Womack and Cole[45] presented the theory that the thyroid gland may become hyperactive in some hypoglycemic states because a function of the thyroid secretion is to mobilize sugar from the liver. They cite two cases in support of their hypothesis: in one an apparent, toxic goiter disappeared after partial resection of the pancreas, though no adenoma was visualized.

Shelburne[37] reported coincidental adenomas of islet cells, parathyroid gland, and pituitary gland in a young man.

In the case reported by Greenlee,[20] cited above, there existed also cholelithiasis as well as adenoma of the thyroid. Cholelithiasis likewise existed in a fatal case of adenocarcinoma of the islands of Langerhans reported by Rynearson.[36] Graham[19] refers to a case reported by Smith and Seibel which at autopsy disclosed pancreatic adenoma and cholelithiasis. Allan, et al.,[3] found duodenal ulcer associated with two adenomas in one patient. Wilder[42] reported the successful surgical treatment of an adenoma associated with hepatitis and cirrhosis.

TREATMENT AND RESULTS

Uncomfortable and inconvenient are surely the mildest terms applicable to even the earliest manifestations of this condition. As the disorder progresses the increasing severity of the symptoms jeopardizes both social and economic life. More important still, irreparable damage may be done to the central nervous system by repeated or prolonged attacks.[7, 11, 31, 32, 39, 42] Delay in treatment allows obesity, which naturally follows the required increase in carbohydrate intake, to increase the hazards of surgery. Furthermore there is always the possibility of malignancy developing.[32]

It is universally agreed that for hyperinsulinism due to adenoma of the islet cell the only cure is surgical removal of the neoplasm. Dietary or other measures may offer temporary means of controlling the symptoms but the time inevitably arrives when such devices fail. In one of the successfully treated cases reviewed, the patient was eating seven times in twenty-four hours and still experiencing incapacitating attacks.[8]

As one writer has stated, all cases of hyperinsulinism due to benign adenomas may be cured by surgery, provided that the operator is able to locate the neoplasm.[26] A possible exception is a case reported by McCaughan and Brown and cited by Frantz.[15] But if surgery has been delayed too long some of the symptoms, such as incontinence, aphasia, mental confusion, or incoordination may remain;[7] or the first operation may fail to bring relief because of the existence of one or more remaining adenomas.[19, 46] In the former circumstance the blood sugar will return to and remain within normal limits following surgery, while in the latter instance the removal of the first adenoma will bring about, at best, only a partial or a temporary improvement in blood sugar values. However, if the condition is recognized before irreversible damage is done and if all neoplastic tissue is found and removed, then the prognosis is excellent.

CASE REPORT

The patient, a housewife, aged 65, was admitted to the hospital Oct. 15, 1947, complaining of repeated attacks of fainting frequently associated with periods of unconsciousness.

History: These attacks had begun six years previously during a time of unusual physical stress, and were initiated by a feeling of extreme exhaustion, mental anxiety, and faintness, followed by periods of unconsciousness which occasionally persisted for as long as five hours.

Her first attack occurred during the summer of 1941, after an afternoon of tiring work in the garden. Feeling completely exhausted she lay down to rest for a few minutes. Much later she was aroused by her sister, after considerable difficulty, to eat supper. At that time her speech was thick and she was unaware of what she said. She had seemingly recovered by morning, and attributed the episode to fatigue and "nerves." Shortly after this, while attending a moving picture theater, she complained of double vision, a symptom which persisted periodically throughout her illness.

During the autumn of that same year she experienced a second attack while working rather hard in the yard. After raking leaves for some time she felt herself stumbling and "walking like a drunk person." Faintness and thick speech followed.

Rather early in her illness the patient discovered that the ingestion of sugar would ameliorate the symptoms, and on admission to the hospital she was consuming as much as two pounds of sugar per week, in addition to her regular diet. To obviate being found unconscious in her bed in the mornings she kept sugar on her bedside table and took it regularly during the night. In spite of this precaution, through the years the attacks became progressively more frequent and more severe until she had reached the point where either failure to take sugar on schedule or the slightest unusual exertion would precipitate an attack, and the patient realized that "something must be done."

Some indications of personality change were noted. The patient felt that she was becoming increasingly ill-tempered in her dealings with her family. She had formerly "loved to cook" but now found it "too much trouble."

Family and Past History: Her family history was non-contributory. Her own history, prior to the onset of the present illness, was essentially negative, except for the usual childhood diseases. Previous operation—thyroidectomy for nodular goiter.

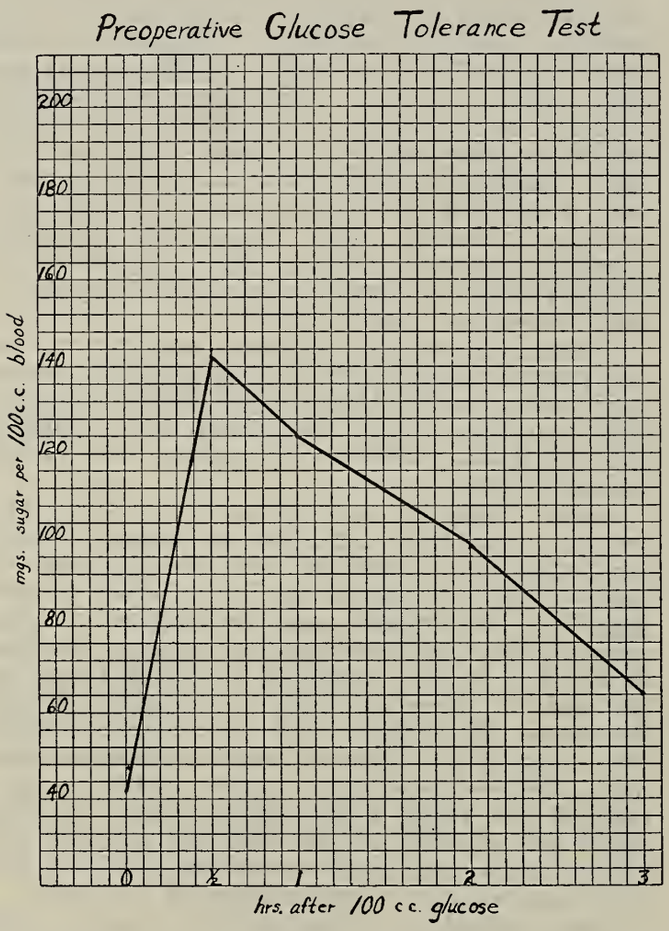
Physical Examination: The patient was a well-

developed, obese, white, married female of the age stated. Skin—some dryness of forearms; no areas of pigmentation. Head—scalp clean. Eyes—pupils reacted to light and accommodation; no exophthalmos; sclera normal in color; eyegrounds essentially normal. Ears, nose, and throat—showed no evidence of acute or chronic disease. Mouth—edentulous; mucous membrane normal.

Neck—no cervical adenopathy; a well healed thyroidectomy scar present without palpable enlargement of residual thyroid tissue beyond normal limits. Chest—breasts pendulous type; no areas of tenderness; no palpable tumors. Lungs—expansion equal; no rales. Heart—no enlargement; no arrhythmia; no murmers; blood pressure systolic 130, diastolic 70. Abdomen—obese; no tenderness; no palpable enlargement of the solid viscera; no palpable masses.

Uterus—small, freely moveable; no palpable pathology in either uterine adnexa. Rectal examination negative. Extremities—normal range of motion; varicose veins, grade II, of both legs.

Laboratory Examination: Blood—RBC 4,200,000; hemoglobin 88 per cent; WBC 10,000; Kahn and Kline reactions were negative; blood urea nitrogen was 15 mgs.; creatinine, 1.9 mgs.; blood amylase, 22.4 mgs. Fasting blood sugar estimations in milligrams per 100 cc. of blood

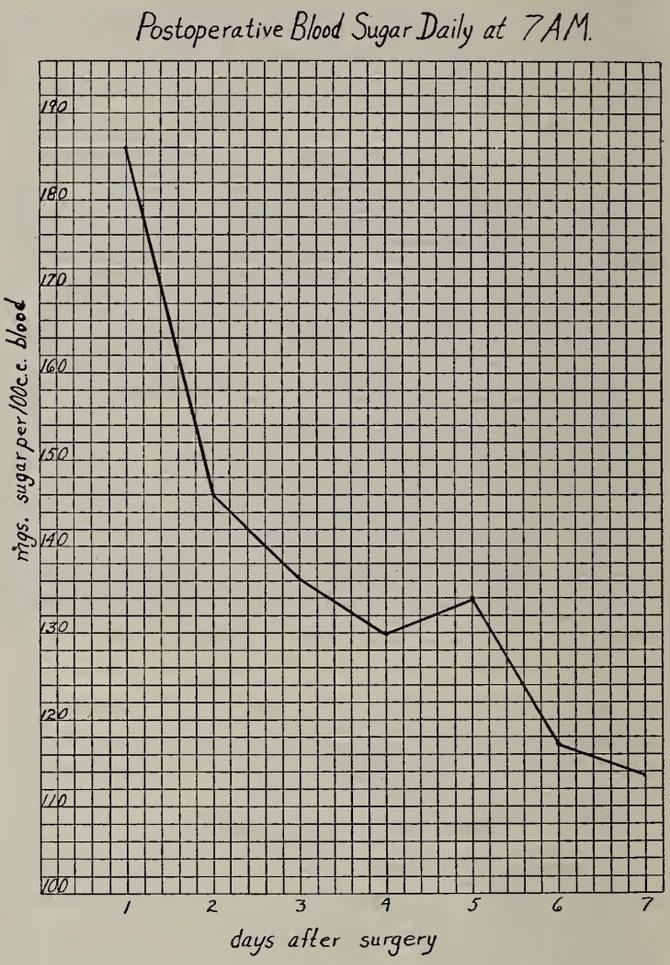


ranged from too low to read to a maximum of 35, preoperatively. The accompanying graph shows the results of a glucose tolerance test. Urine—contained no albumin and no sugar; acid reaction; specific gravity 1.017; microscopic examination negative. X-ray of chest—lung fields are free of parenchymatous disease. X-ray of gallbladder—after oral administration of dye, revealed a functioning gallbladder which contained one large stone.

Preoperative Diagnosis:

1. Functioning islet cell tumor of the pancreas.
2. Cholecystitis with cholelithiasis.

Preoperative Care: One hour before the patient was taken to surgery the administration of 1000 cc. of 5 per cent glucose in distilled water was completed. Blood sugar immediately before



the operation was 180 mgs. per 100 cc. The usual preoperative hypodermic of morphine gr. 1/6 and atropine gr. 1/150 was administered.

Operation: Under endotracheal nitrous oxide ether anesthesia the abdomen was opened through an upper transverse abdominal incision. On palpation a tumor about the size of a large pea, firmer than the surrounding pancreatic tissue, could be felt in the body of the pancreas. The gallbladder contained a solitary stone. The remainder of the exploration of the abdomen gave negative results.

The pancreas was then exposed through the gastrocolic omentum, and a careful search of the gland revealed no other neoplasm. When visualized the tumor presented a bluish, granular appearance. It was excised and the bleeding controlled with suture. The abdomen was closed without drainage.

Pathological Report: The tumor measured 1.5 x 1.3 x 1.4 cm. and weighed 1.6 grams. It was firm and encapsulated. On section it showed a central portion of white, firm, apparently fibrous tissue which sent radiating processes toward the periphery. The approximate area of this fibrous radiation was 0.6 cm. The peripheral portion of the tumor showed a brownish-gray, resilient, translucent structure.

Under microscopic examination sections displayed a fairly high degree of fibrosis in the central portion. The parenchymatous cells of the tumor consisted of well-circumscribed, small

to large masses. The cell outlines were indistinct. The cytoplasm was finely granular to slightly foamy and took a light basophilic stain. The nuclei showed considerable variation in size, shape, and chromatin distribution as well as in density. A number of quite large hyperchromatic nuclei were present. Pathological diagnosis—islet cell tumor of the pancreas.

Postoperative course: The operation was completed at 10:30 a. m. At 12:30 p. m. the blood sugar was 200 mgs. per 100 cc.; at 6:30 p. m., 180 mgs. per 100 cc.; at 9:30 p. m., 108 mgs. per 100 cc. During the first twenty-four hours after operation the patient received 1000 cc. normal saline solution and the same amount of 5 per cent glucose in distilled water.

Twenty-four hours following surgery the blood sugar was 148 mgs. per 100 cc. On the twelfth postoperative day the fasting blood sugar was 90 mgs. per 100 cc.

A check-up nine months after surgery again revealed a blood sugar of 90 mgs. per 100 cc. and this patient has presented no symptoms of hypoglycemia since excision of the adenoma of the islands of Langerhans.

SUMMARY AND CONCLUSIONS

1. A reasonable search of the literature reveals 130 successfully treated cases of hyperinsulinism due to islet cell adenoma.

2. The incidence is probably greater than commonly realized; only a minority of the adenomas produce symptoms, and many of the latter group probably are not recognized.

3. This syndrome may occur at any age.

4. The disease progresses toward irreversible changes in the central nervous system, coma, and death unless arrested by surgery.

5. When the causative adenoma can be found and excised before irreparable damage is done to the central nervous system, the prognosis is excellent.

6. A successful surgical case, followed for nine months postoperatively, is reported.

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Mesenteric Cyst: Case Report of Successful Removal Without Resection of Adjacent Bowel in Infant

JOHN M. STRAIT, M. D.

THE incidence of mesenteric cysts is very low. Ladd and Gross report 26 cases in a fifteen-year period. They are true congenital cysts, and have been classed under reduplication of the alimentary canal. Microscopically, these cysts are lined with columnar epithelium. The cyst reported was lined with stratified squamous and pseudostratified cileated columnar epithelium. The cyst was covered with circular and longitudinal smooth muscles coats that were continuous with the coverings of the jejunum.

It has been postulated that these congenital cysts arise from remnants or misplaced bits of endoderm. The case in question would seem to have arisen from ectoderm, as evidenced microscopically by presence of tracheal and dermal epithelium.

The blood supply of the gut is usually compromised in dissecting these cysts from the leaves of the mesentery, therefore making it necessary to resect the devascularized bowel. The lumen of the cyst may communicate with the adjacent bowel, or be so closely adherent that dissection is hazardous. This is another reason why resection of involved bowel is advised.

In this case the cyst was dissected from the leaves of the mesentery.

CASE REPORT

Admission No. 10531, Samaritan Hospital, Ashland, Ohio. J. P., a two-year old white male child, became quite irritable and appeared to have colicy pain in the abdomen. His mother noted a large mass in the right side of his abdomen which she stated had not been present previously. No previous attacks, child always had been normal and healthy. No bowel movement on day of examination. No vomiting. On examination, the pulse was 100, the temperature was 100.2 R. The child appeared quite excited but not acutely ill. The mass in the abdomen was quite evident on inspection. It was about six inches long and two inches wide, lying in the right side of the abdomen, somewhat movable, and very firm on palpation. Rectal examination revealed absence of any impaction and the tumor was palpable, resembling an indurated mass.

Ileocolic intussusception was suspected, but the child did not appear ill enough to warrant the diagnosis. However, the onset of symptoms being only two hours before admission, it was still the most likely diagnosis. X-ray of the abdomen revealed gas in the transverse and descending colon. The red blood count, white blood count, hemoglobin and differential were: Red blood count, 3,970,000; white blood count, 18,250; hemoglobin, 61 per cent; polys 43 per cent; lymphocyte 56 per cent; monocyte, 1 per cent; (31 stabs 12 segs). Urine: Yellow, clear, pH5, S. G. 1.025; sugar and albumin, negative; Micr.: neg.

Operation was advised due to the possibility of intussusception. Delay might necessitate resection of the bowel, due to gangrene.

Submitted December 13, 1948.

The Author

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OPERATION

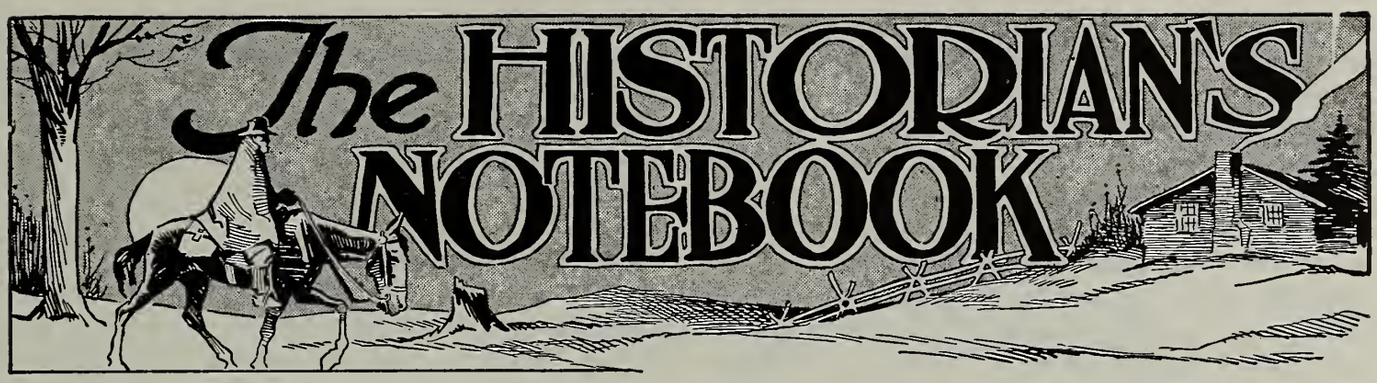
August 21, 1948, under open-drop ether anesthesia, a lower right rectus muscle splitting incision was made. On opening the abdomen, it was apparent that the tumor was a large cyst of the mesentery. The incision was extended upward. The cyst was mobilized and delivered into the wound. The right leaf of the mesentery was quite avascular, and this was split in the direction of the bowel, which extended over the cyst. Dissection proceeded easily until that portion in contact with the mucosa of the bowel was encountered, and here slight bleeding took place, but no tears occurred. After removal of the cyst, the mucosa of the mesenteric border of the jejunum was exposed, but appeared to have an adequate blood supply. Consequently, the muscular coats of the bowel were approximated with chromic catgut and the defect in the mesentery repaired with continuous chromic catgut No. 0. Clips to the skin. Postoperative condition excellent. Duracillin, 300,000 U. I. M. daily for three days.

PATHOLOGICAL REPORT

Gross Description: Specimen is in two parts, the larger of which measures 6.5 x 4.5 x 3.0 cm. It is cystic in form but its contents have been removed. Its wall is thin and its lining is smooth. There is also a mass of blood clot.

Microscopic examination and diagnosis: Cyst is lined by stratified columnar epithelium which is ciliated. In the wall there is a smooth muscle arranged in definite layers. In some areas the epithelium is squamous in type. Developmental rest, probably representing some portion of the primitive alimentary tract. No malignancy.

The child made an uneventful recovery, taking water p. o. 12 hours postoperatively, and was discharged after removal of the clips on the fourth postoperative day. On examination the eighth postoperative day, the wound was healed, and the boy was eating a soft diet, and having daily stools.



Soliloquy on a Dead Fish

MARTIN FISCHER, M. D.

BORED stiff as I have always been by the recitation of any fish story, I inflict this one on you.

What I recount derives from several trips into "deep-sea" territory off Maine. For me it stretched from Marshall Point some twelve miles south. The ocean there runs forty fathoms, and it's all yours. Geodetic maps do not indicate the spot but Captain Earl Fields knows a ledge which tops at twenty-five. It divides in two the incoming or the outgoing ocean swell and so the animals that travel with it. If fortunate enough to be with this master, your hooked line can here touch bottom. You work at four to six feet above this level. But do not think that because you bring up something enormous every few minutes, you are thereby made worthy to be called a fisherman. Every fool does it. His luck is better and bigger on certain days than on others for reasons which are anybody's guess; but it is always good.

Chief talk concerns poundage. Two professionals attained this summer's record with three thousand pounds caught in twenty-four hours. Seven laymen of the Captain's caught two thousand pounds in ten. Even a moron cannot come home without several hundred. If he does, it is because he left his hook below more than three minutes; and the fish ate the bait. Catch runs pollock, cod and dog-fish in this order, with cusk, haddock and conger eel thrown in for special measure.

BIOLOGICAL PHILOSOPHY

To bring up by hand a fish mass the quarter your own size is something; consideration of the fact, something much more. So after you have measured and admired the outsides of your catch, cut it open and regard what is inside. Deep-sea fish are built to pattern. If you draw for example on a cod, note that his head is the third of his total length. This is necessary to give him breath; but it is equally necessary to catch and to hold on to his prey. The maw drifts funnelwise and without apparent interruption into a stomach which extends to the lower third of his total anatomy. Remember that the Anglo-Saxon meaning of cod is bag. This means that except for the activity of sex, his bulk is devoted to one business only, that of getting something to eat and its digestion—a conclusion at once verified by finding within these creatures up to ten herring in all stages of alimentary disintegration.

What you have in a fishing boat is a ringside seat in God's theatre of life. The play is always a tragedy and without all relief scenes. As the picture I have drawn demonstrates, life lives on life. Every creature leaves the surface of this planet to succor, nourish, in the end to become the thing that killed it, even up to the level of man. His ingenuity in the centuries past and today aims to stay his own descent to death and dissolution but the time for it is not infinity as so many suppose. In uninterrupted nature, all animals die as soon as they prove themselves not the strongest and the best of their species. Only man ever grows old. This

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Submitted April 2, 1949.

is the Wallace-Darwin law of the survival of the fittest, and it holds even for the domesticated animals which, when not killed for human consumption in adolescence, are butchered later for dog-meat when their labors no longer satisfy an employer. It is the law of the jungle; but as I would emphasize, it is that of the city, too. Man has believed himself capable of bypassing it, but as is to be seen, not even he can escape it. The cruelty of the drama is such that the biologists of the Victorian era found need to apologize for it.

THE INORGANIC AND ORGANIC OF NATURE

The immobile of nature is called the inorganic of our world; its moving form, the organic. The first is the cosmos of the mineral, the second that of the living, organized things which inhabit the earth. There's a chemistry of both. That of the latter is called organic chemistry, more specifically the chemistry of the compounds of carbon. But carbon is *not* the element of greatest price; it is nitrogen! As my teacher, Walter Stanley Haines, taught me fifty years ago: "Nitrogen by itself is the deadest of the chemical elements but once in combination, the livest; it is the essential of every food and the deadliest of all poisons; it constitutes the world's finest perfumes and its greatest stenches."

The plastic which is life is designated protoplasm. It is a nitrogen compound, in its complex state called protein. Fat and carbohydrate get mixed into its matrix and serve useful purpose; but protein remains the architectural frame of everything called alive. There is no life without it and every organism, plant or animal, struggles for it. While the fight is for anything called food, principal clamor is for that fraction of it which carries nitrogen.

The founders of the science of nutrition, Pettenkofer and Voit, in 1860 correctly divided all of what is taken in as food into two parts —grammes protein and calories. Nothing has been added to this first declaration of what is the necessary for the creation, development and sustenance of the living thing (even though various inorganic elements and the so-precious vitamins deserve consideration). If you want flat statement of what is required to keep going the average healthy human, remember that a white-collar adult in U.S.A. lives on 125 grammes of protein and 2500 calories per diem. Said more practically, he takes in as food a pound daily of meat, fish, eggs or fowl and more than a pound of breadstuffs and fat.

The living thing is protein; it requires protein for its growth and repair; and it does its daily chore best on protein. Calories from other source "save" the poor thing but they cannot replace it. Some calories go with protein—four to be specific with each gramme thereof. On this account, enough meat can by itself keep man in physiological state—as the Arctic explorer, Vilhjalmur Stefansson declared forty years ago. Calories derivable from starches, sugars, and fats "spare" protein from too immediate consumption in the mill which is life, but that is all. You can get all the calories you want out of granulated sugar, tapioca and butterscotch, but at best they are only oil on the machinery of protein. Every living thing is such a machine and requires for continuance the materials of which it is built; grease delays but cannot stop trip to the junk pile.

NUTRITIONAL SCIENCE POLITICALLY APPLIED

Now observe what dunces governors, legislators and politicians are! I indict the world but take illustration from our own. U. S. A. tax collectors once believed that a thousand dollars a year should be spared every adult as unassailable income-need for his maintenance. A fifth this amount—namely two hundred dollars might be exempted for each child. These are the facts! The food demands of a one-year-old infant are 80 per cent those of the parents'; and a twelve-year-old boy or girl requires their equivalent!

In 1932, Henry Agard Wallace ordained an auto-da-fé of the pigs. I made several trips into the south thereafter to moan because unable to buy even one southern ham. But needed I to shed tears because a populace had listened to the false prophet and had come to hold a government check worth more than a hand free from pellagra?

American thought owes a third title to idiocy to another Henry—surnamed Morgenthau. He claims authority as a physicist, one expert on the value of the calorie, especially as present in food. The bum who graces our parks—the "bencher with no compelments"—won't be there long unless assured of at least 1800 of them each day. Admitting that there are no good Germans, Mr. Morgenthau allowed 1200 to such as did prove up. On this quantity the human frame cannot push itself around the house, much less do any work. The survivors of Europe rode out a storm by going to bed. A group of conscientious objectors in our country submitted themselves as guinea pigs to trial of the effects of this low calorie diet. They shrank to skeletons, could do nothing, lost all interest in sex. To the surprise of our New Deal evangels, they lost all interest in "democracy" too. Morgenthau's giants in economic reorganization did not even mention grammes protein in their replanning of this brave new world.

If starvation was required of the Central allies for their recivilization, those who did them in, particularly the British, got it for nothing.

They lived on the brink for years—and do still. But even the virtuous may not be subjected to a dietary regulation which lies below the nutritional minima of any organism without lasting harm. It incurs a physical, mental, and moral debt which no amount of return to "normalcy" can ever wipe out.

WHENCE LIFE

Essential to the feeding of anything alive is nitrogen.

This stuff makes up 80 per cent of our atmosphere but in this form most of the world of plants and animals cannot use it. Of this date, only the nitrifying bacteria can build themselves out of, and maintain themselves upon, the nitrogen (or the ammonia) of the air. These forms are important because from them comes the food by which higher plants, like the peas and the beans, live. Man tries for similar end through "fertilization" of his crops. It requires "manure"—the nitrogen-containing dung and urine of animals, or the rotted remains of bygone vegetables and animals. Recall that the friendly American Indians taught the Pilgrims not only how to plant maize but how to fertilize it afterwards by planting alongside, a fish. Modern chemistry has learned how to "fix" atmospheric nitrogen. The product is today's substitute out of Niagara Falls or the Tennessee River for what were once the piled-up remains of earlier life forms contained in South American guano or Chile saltpetre.

In the struggle for life, it is better to be a turnip than a Plato. This is because vegetables can go on their own but animals only because a vegetable world preceded them. Animals are supposed to live off the carbon compounds found in plants but actually they live off their nitrogen. The carpenter-ant and the termite produce sawdust but get their sustenance out of the protein they suck up in the process. In this way animals may be called the condensers of the low percentage of nitrogen contained in plants into the higher of themselves. The so-called herbivorous are best at this game but even their well-being does not rest as much upon the 80, 90 or 95 per cent of starch or fat they take in as hay or grain, as upon the remaining five per cent of protein.

Man is said to be an omnivore; this rates him biologically with the swine. Top animal rank belongs to the carnivores, who cannot in any circumstance make themselves into vegetarians, Theosophists, or Adventists. The latter so often end in asylums because hominy, white flour and molasses can neither build nor maintain a normal central nervous system. They live at all because they cheat. While unwilling to kill, they do not object to the taking of milk or eggs. There is no better source of protein! Milk is literally the liquefied tissue of the mother, any pint of which is the equivalent of any pound of her flesh; and the ounce chick has made itself out of the ounce of egg that mother laid. It allows the zealot to escape the charge of murder; but not that of kidnapping and robbery.

LIFE LIVES ON LIFE

How the struggle for life is in essence a struggle for nitrogen is apparent from many sides.

Poultry opinion has it that a chick needs to scratch. Actually no animal makes muscular effort except to get something to eat. The chick is on hunt for a worm and so the picture of frustration, as the freudians say, when it tries to get this protein out of a cement flooring. The only reason why the thing manages to attain debutante level—meaning the time at which it can be killed as a spring chicken—is because fed "scratch" food. This is patent medicine name for the nitrogen-carrying "refuse" called "middlins" derived from man's flour mills. Man rejected this very staff of his own life long ago, to attempt it on the bill-posters' paste left behind. Failing in this quest, he now adds to his diet a five-dollar can of vitamins made from the very stuff he threw away.

Even the herbivora turn carnivorous when circumstance permits. Last summer I brought four adult rabbits and a pig into excellent market form by feeding them dog meat and fish. The Norwegians have long revived their droopy horses with a salt herring. As a friend of mine who manufactures race horses tells me, his win more often because he adds blood, bone meal and slaughter-house remains to their standard intake of grass, hay and grain. To appreciate how much harder the herbivores must work for their protein ration than the carnivores, recall that the gut of the former is three times as long and capacious as that of the latter.

Seed-eating birds are such only in the fairy tale. The hook-nosed variety are admittedly carnivorous and may, when caught as pets, be lucky enough to get meat. But "bird-seed" is the portion of the straight-billed. They decline on it, lose weight and, more important, their feathers. As my feeble-minded associate in the pet-shop knows: "The feathers strike in on them." Only animal products maintain any bird, allow it to develop feathers, to lay eggs. Both the latter are protein.

HOME SWEET HOME

We've had Jerry, our crow, in the laboratory some nineteen years. Come up and see her sometime, and stroke her sleek feathers. She's straight-billed, classified in consequence with the seed-eaters. She has been offered every variety

of them but is still due to commit her first error by eating one. Her meals consist of eggs, sausage, sausage-casing (not made of cellophane), cheese and bone.

Before Jerry, we had Dacey. She was straight-billed, too. In the flesh she was an Australian kingfisher, sometimes called the laughing jack-ass. If head size is guide to intelligence, Dacey had it plenty, for God makes the head of any kingfisher the fair half of its entire body. I won't tell how or why I got to be her foster-father; but I did. Being a social uplifter by profession, I wanted to reinstitute for the waif proper home surroundings. I succeeded—by feeding her in live state, five gold fish and two green frogs daily. What did Dacey do with her daily catch? She would duck into her aquarium and pitch high the fish so caught, to make it slip downwards head first. The frogs got special handling. Grasping one of them in a claw, she would beat it to death on a rung, swallowing the fractured mass whole. After every such episode, she retired. Three or four hours later she would vomit the skeletons of the animals she had downed. No anatomical *preparateur* ever made neater job.

If Dacey's way of life sounds scandalous to you, learn that it is the way of all nature. Her habit is not only the way of all birds but as I have tried to describe, of all fish. It is the way of all beasts too, not only those acknowledged to be meat eaters but those said to be herbivorous but glad to be fed protein.

THE ECONOMICS OF NATURE

Life's battle for continuance on this earth remains the question of who will eat whom. The product yields what is called the "balance" of nature—that beautiful equilibrium seen to exist between the birds and the flowers but also among the animals. Now observe that the fight of man against nature or against himself is no exception to this law, not even when new and special terms are applied to his mode of life. *Homo sapiens* remains the sap (this is not a play on words) when he sees himself either the product or the subject of an "economy"—financial, material or political. He is at all times the vassal of a biological law which no set of "managers" or "planners" of an "economy" for him, can change. He lives only because he eats; and he does not eat unless he produces. The dictators or the agents of democratic, New Deal, socialized, sovietized or communized governments who believe that they can sidestep a law of God, are beaten before they start.

ORNITHOLOGICAL BEHAVIOR

But to get back to the sea!

As you head for port after your catch, there is not a bird in the sky. You begin to clean up and throw overboard your unexpended bait of shelled clams. One bird appears, ten follow, a hundred. They are gulls, courmorants, sometimes terns. Their classification by the systematic zoologists does not matter, for all hover over your boat and splatter it in identical fashion. They never leave you on the long ride home, hoping that something more will drop overboard. Toss them cracker, bread or popcorn and see how it goes unnoticed. What the birds want is meat. You throw overboard the herring you brought along. A gull's swallowing of one such astonishes you; but it can do better. The master of the ship orders overboard the too-small-to-be-salable cod. You do; to wonder how one small bird can swallow what seems to be the half his weight and not die at once.

Belief is that these creatures will not eat dog fish. That faith is in error, as I found, for the largest of the sharks go the way of all flesh as soon as reduced to swallowable size.

The provision of enough food (more particularly, sufficient meat, fowl, fish, milk and eggs) to all members of the human family is something taken for granted. Yesteryear had a phrase for it: this world owes every man a living. I ask, just why? and—to cite Sumner—who is the guy responsible for the owing?

MORE FISH FOR FOOD

One trial at keeping man adequately fed with protein has lain in the capture for him of fish. Thus not only more, as in the centuries past, but different inhabitants of the waters have been brought to land to succor man.

In 1900 when at Wood's Hole in Massachusetts, the first swordfish were brought in by the captains of the two supply boats on week-end cruise after the demands of the biologists of the marine station there had been satisfied. They rated inedible and so were introduced to the table of a "mess" instituted there and patronized solely by naturalists who could not afford more than five dollars for the weekly board. Their one-time provender now sells to the public at seventy to ninety cents the pound.

U. S. A. beatified another fish in 1915. The Japanese had long prayed to the tuna, to catch which they invaded our West Coast. Success in this line did much to keep their increasing population alive. Not until the first world war did we become tuna-conscious. If you care to estimate how far we have come, connect up with a restaurant and ask how the orders for tuna stand. A menu that does not carry tuna in chief is unknown to any cafeteria—that horror of man's progress.

I would like to see the dog-fish given proper rank. It is something just as good as swordfish or tuna but considered below class because called shark. This is akin to U. S. A.'s prejudice

against horse flesh (even though every American traveller in France goes crazy about *Chateaubriand* steak which in the original is horse). Similarly we hate snake; also eel, because it looks like snake. The maligned of these species should take their case to court and ask that their names be changed. Grasshoppers go down better if called *manna;* maguey worms, if designated *gusanos;* land snails, as *escargot.*

Shark is hated by the landlubber because an unsought-for catch. It is more hated by the fisherman who when he snares one goes mad, hammering the poor thing to death, ripping off its chest plate and dumping the torn carcass overboard. There's no market for him, as said. Yet he makes excellent fertilizer, dog and pig food. Second count against him alleges that he eats fish; but, as this tale has related, so do all fish. This includes the whales which are not fish at all but mammals. Reread *Moby Dick* for the statistics or if the volume is not handy, visit a port and see disgorged from one whale's stomach a whole school of once living herring.

YOUR LIFE OR MINE

The biological law that life subsists on life, so assailed the conscience of Alfred Russell Wallace that he sought spiritual quiet. He found it by saying that it was all God's plan and that he had nothing to do with it. Thereafter he softened further the outlines of nature's crude pattern by pointing out that death in the excitement of the chase is painless. This was good guess into the future of physiology, for it is true that in the emotional drunkenness of battle—as in war, a prize fight, a Roman arena —the victim may lose his members without consciousness of the fact until later. It justifies the Spanish matador—the death of a crazed bull in the circus may be a more happy way out for him than his death in a butcher's pen. This does not defend bull-fighting but it does condemn the matter-of-fact way in which a public accepts the killing of thousands of animals daily that it may live. Nature is a mobile slaughter house; man has made it sessile. Instead of shooting a buffalo on the prairie, he executes a black Angus on the abattoir floor. Is no obligation incurred? I like Gibran's Prince, who as he turned toward home, gave thanks to the human company which had befriended him —and to the animals which had died for him.

I, too, live in a moral clutter. Every species of life proliferates until the edge for its starvation is reached. This keeps the living world within bounds, from which law man is no exception. How can anyone like myself square his advice to him to eat more meat with the fact that this calls for increased slaughter? I refuse to answer. Is mere increase in numbers born, a virtue? Is everybody born entitled to live? Is everybody alive entitled to eat? If so, why?

SHOOTING THE SITTING PHEASANT

From the killing of the wild, man entered upon the killing of the tame. For centuries past, he has "domesticated" stock, to slaughter it at his pleasure, not because physically superior but because smarter—he invented the hammer, the sword and the gun. Thus he converted the clean of sky, field and sea into the dank of the abattoir.

Do the animals concerned have nothing on their side? Revert to the incident of seeing thirty pounds of beauty dying at your feet; or add to this fish story the shooting of a deer or a bird. I cannot envisage these matters as "sport." A surface-swimming giant is brought aboard because whipped to exhaustion; one deeper lying, because jerked into the intolerable level wherein it dies of the bends. The picture is that of a clinic, not a picnic ground.

As the supreme of creation, man escapes the charge of murder for his killing of fish, flesh or fowl by saying that he needs them for food. It is by this trick that he has spread all over the globe. But what is the merit of it? What have Mussolini's, Hitler's or Stalin's millions added to the glory of God? What did the Canadian government contribute when it subsidized the quintuplets?

THE APPROACHING NIGHT FOR MAN

Fifty years before Wallace and Darwin (specifically in 1798), T. R. Malthus pointed out that population increase or its recession paralleled the availability of food. So many of mankind live as can live miserably. (I put in a modifier by saying that so many of our kind live today as are content to live miserably.) This dictum was howled down because offensive to the Christian missionarying spirit, yet more because the statistics referred so largely to Africans, South Sea Islanders and Frenchmen—forms of life naturally abhorrent to the self-restraining Englishman.

It was still a leading question in my youth: Can man's increasing control of nature keep ahead of a defined limit? Nineteen hundred said, yes; and could adduce many proofs. In 1850, for example, the trek west was opening new and fertile lands; and Cyrus Hall McCormick had invented the reaper—a machine which made the farmer capable of harvesting forty acres instead of four. Three slices of bread with any fifteen-cent meal, dates from that moment. To which facts add the irrigation ditch and man-made manure. For decade upon decade the emigrating millions out of Europe were not only to live, but to live better.

It proved Malthus a sick man. But was he? Even in his day China and India were already at stationary population—self-imposed through infanticide, imposed from without through lack of food. Where would Japan have stood if she had not gone fishing in deeper waters, as the Norsemen had found necessary centuries before? To meet famine in India, England built dams and improved transportation. Today there are twenty-seven million more of them clamoring for the extra rice.

ONLY WORK GAINS FOOD

Is the spectre of famine or the attempt at the closeting of it, different as of today? If you so affirm, then why have even we been plagued with ration cards, red points and queues in the market? Why at this moment more tuberculosis, malaria and death in the cold for the world? And why increase for us in the children born to G. I.'s?

While a plague inspector in California years ago, the Japanese used to conduct me into the rooms where lay their dead by squirting perfume in my face. That's my concept of what the political wizards of today are doing to the stench of economy. I use the term as university synonym for the world proposition that dog eats dog. How to be the eater and not the eaten depends upon which of the two is the stronger. All of which is Irish for stating that only he survives who works hardest and best.

The lemmings arise every few years at the thaw line of Scandinavia. They eat the available food and breed. To find more, the progeny has to travel, and so proceed toward the sea. Additional food appears but not enough to bring to halt a hegira. The urge goes on until the sea is glimpsed. Then they jump off the cliffs or pile up on a beach and drown. It's all due to the urge of sex, say some. The psychoanalysts have different answer—the lemmings cannot take the world story, and therefore commit suicide. But isn't it simpler? When food no longer satisfies popular demand, they turn cannibal and in a last stand, kill each other.

That's war.

THE NEXT GLORY

Gas was not employed by the victors in the latest insanity; nor will the conqueror in the next war use a seeding with death-dealing plagues. I forecast that the atomic bomb will never be used again. Clouds of radioactivity drifting for hundreds of miles beyond a point of detonation, upset the health. Not only men but the fishes die, and eaten by others, they die. There's no end to the process in foreseeable time. Victory in war no longer leaves behind anything worth having. Working under the humane standards of the militarists, the next commander-in-chief will employ nothing beyond a spray gun with something in it akin to "flit." It will kill only insects but no larger animals or man. Thereafter the flowers will not fruit and the grains will not sprout. Victory will come not tomorrow but in a few years—through starvation.

Man may not wish to worship God; he has to. This is because God is the Law. The Russians read Him out as a nuisance; and a proletariat believes that its wishes can be made over into statutory laws superior to His. Neither kings, dictators and racketeers, nor clerks, standins, and men with dandruff in their hair can win that way. Only scientists who pray have kept or can keep mankind out of hell.

Case Reports 100 Years Ago

No. 40. Miss L., aged 8, Franklin County. Disease of the ear. For several years this little girl has been affected with a slight deafness with constant discharge from the right ear. As a test of the soundness of the drum of the ear, she was directed to make a violent expiration or blow out her breath, while at the same time the mouth and nose were forcibly closed. On attempting this, air rushed out through the right ear membrane with a rough whistling noise, which showed that the membrane tympani was destroyed by ulceration. The doctor remarked that the ulcers within the ear might be healed by stimulating washes and so on but that the destroyed membrane could not be restored, and, therefore, the hearing of the child was irremediably impaired.

* * *

No. 42. A. J., Aged 4 years, Madison County. Hip Disease. About the first of May last this little girl, who has a scrofulous diathesis, began to complain of slight uneasiness and pain in the right hip. One month subsequently she was observed to limp when stepping upon the right foot. These symptoms gradually increased through the summer, until she was finally unable to bear any weight upon the body upon that limb. At present there is every evidence of scrofulous disease of the head of the thigh bone, which the doctor remarked, would terminate the life of the little patient, or in abscess or dislocation of the joint, unless the disease were arrested. He dwelt with emphasis upon the insidous and constitutional nature of the disease, and in the treatment enforced the importance of entire rest to the joint and such constitutional and local remedies as are calculated to sustain the vital powers and prevent disorganization of the joint.—*Ohio State Journal, Tuesday evening, Dec. 4, 1849.*

Hospital Training Facilities . . .

Ohio Hospitals Are Offering Intern Training for 478 Doctors, and Specialty Training for an Additional 983, A. M. A. Report Shows

As of May 1, there were 807 hospitals approved for intern training, according to the annual report on internships and residencies by the Council on Medical Education and Hospitals of the American Medical Association, as printed in the May 14 issue of the *Journal of the A. M. A.*

This number includes hospitals in the continental United States with one in the Canal Zone, one in Guam, four in Hawaii and six in Puerto Rico. The list contains the same number of hospitals as that of last year, although there have been changes in the names. There has been an addition of 39 hospitals with the same number removed.

The 807 approved hospitals include 37 under Federal control, 118 governmental hospitals other than Federal, 15 proprietary, 305 church sponsored and 332 organized on a non-profit basis.

These 807 hospitals offer a total of 9,124 internships. Of this number, 500 internships are offered by the Federal services, with the Navy listing 189, the Army 157, the Public Health Service 124 and the other Federal Security Agency hospitals 30.

Leading the list in number of internships were New York, Pennsylvania, California and Illinois, with Ohio fifth.

The number of hospitals approved for intern training has increased by 10 per cent during the past ten years, while the number of internships offered has risen by 16.4 per cent. The number of medical school graduates meanwhile has not increased proportionately with the result that approximately 20 per cent of the internships offered have remained vacant. The percentage of vacancies in Ohio hospitals, according to the Council report, was 26.7.

A significant factor contributing to the increasing shortage of interns in approved hospitals is the decrease in the number of eighteen-month and two-year internships, with a subsequent increase in the annual demand for interns by hospitals which formerly offered appointments only on alternate years.

REVISION OF ESSENTIALS

In November, 1948, the Council on Medical Education and Hospitals completed the first major revision of the "Essentials of an Approved Internship" since 1942. The revision was ratified by the House of Delegates at its St. Louis meeting.

The autopsy requirement has been raised from 15 to 20 per cent. With that exception, the quantitative requirements have not been changed appreciably. Hospitals with capacities of 100 beds and over, maintaining an average daily census of 85 patients and an annual admission rate of 2,500, are eligible for approval.

The Council reemphasized the importance of a well organized program for intern training. It stated that internships arranged merely to provide hospitals with resident personnel to assist in the clinical work cannot be approved. It suggested that appointment of a director of intern education on a full time or part time basis may be desirable in hospitals in which members of the staff are unable to devote necessary time to the careful planning and supervision of details of the internship program.

The attending staff is not to be relieved of responsibility for teaching. The director would correlate the activities. The Council suggests that the intern be given an orientation period at the beginning of service.

ROTATING INTERNSHIP RECOMMENDED

The "Essentials" include the statement that the Council believes that a well-organized rotating internship is likely to provide the best basic training for either the future general practitioner or the specialist. This type of training provides for adequate experience in the four major clinical divisions. Too frequent a rotation of assignments or assignment to more than one service at a time is not considered desirable. The Council recommends that at least three months be devoted both to internal medicine and to surgery and states that any assignment of less than two months' duration is unsatisfactory.

While the majority of internships presently approved are of one year's duration, longer periods of service are considered preferable, since they permit more satisfactory educational program and allow the intern sufficient time in which to be trained adequately to assume increasing responsibility in various fields of medicine, the Council report continues.

For the first time, the "Essentials" provide a method for determining the number of interns to be appointed. The bed capacity of the hospital is used as a basis, with a range of 15 to 25 beds per intern recommended. Consideration should be given to the amount of responsibility required of the intern for work in out-

patient departments, emergency services, laboratories or similar assignments in determining the ratio which the hospital may wish to use, it states.

STIPENDS

Of those hospitals which offered stipends in addition to maintenance, the salaries ranged from $9 to $205 per month in teaching hospitals and from $8.33 to $250 per month in the non-teaching group for the past year. In Ohio, stipends varied from $9 at Ohio State University Hospital to $150 at Flower Hospital, Toledo, with an average of about $60.

RESIDENCY TRAINING

Since last year two additional certifying boards have been approved by the Council on Medical Education and Hospitals and the Advisory Board for Medical Specialties, namely the American Board of Proctology and the American Board of Preventive Medicine and Public Health. The Council now lists approved residencies in 18 specialties and seven subspecialties.

Facilities for residency training in the specialties continue to expand. With few exceptions, the number of hospitals approved for residency training has increased during the past year. The number of approved hospitals rose from 1,102 in 1948 to 1,187 in 1949, an increase of slightly more than seven per cent. The number of residencies offered, however, increased by 2,121 positions, or a rise of 14 per cent.

RESIDENCIES IN FEDERAL HOSPITALS

In addition to their residency programs in civilian hospitals, the Army and Navy conduct training in specialties in six Army hospitals and nine Navy hospitals. Residency training also is provided at 12 U. S. P. H. S. hospitals. Including those available in the Veterans Administration, the Federal services currently offer 3,322 residencies in all specialty fields.

RESIDENCIES IN OHIO

Throughout the country, 17,293 assistant residencies, residencies and fellowships were approved by the Council on Medical Education and Hospitals.

In Ohio hospitals, 983 assistant residencies, residencies and fellowships are on the approved list, of which 119 are in Federal hospitals. The openings in respective specialty fields are as follows: Anesthesiology 20; contagious diseases 4; dermatology and syphilology 16; general residency 4; internal medicine 229; neurological surgery 10; obstetrics and gynecology 73; ophthalmology and otolaryngology 37; orthopedic surgery 38; pathology 55; pediatrics 56; physical medicine 1; proctology 1; psychiatry 61; pulmonary diseases 25; radiology 56; surgery 279; thoracic surgery 3; urology 15.

Openings in Ohio Federal hospitals (included in the foregoing figures) are: Internal medicine 51; neurological surgery 1; ophthalmology and otolaryngology 4; orthopedic surgery 7; pathology 1; psychiatry 11; pulmonary diseases 3; radiology 4; surgery 34; thoracic surgery 1; urology 2.

The following summary shows the number of assistant residency, residency and fellowship openings and specialty fields in which they are offered by respective Ohio hospitals:

Children's Hospital, Akron—Orthopedic surgery 2; pediatrics 4; surgery 1.

City Hospital, Akron—Internal medicine 3; obstetrics and gynecology 4; orthopedic surgery 4; pathology 3; radiology 2; surgery 10.

Peoples Hospital, Akron—Internal medicine 4; obstetrics and gynecology, 1; radiology 2; surgery 9.

St. Thomas Hospital, Akron—Internal medicine 2; obstetrics and gynecology 2; surgery 5.

Aultman Hospital, Canton—Internal medicine 2; obstetrics and gynecology 1; pathology 2; surgery 8.

Mercy Hospital, Canton—Internal medicine 2; obstetrics and gynecology 1; radiology 1; surgery 8.

Bethesda Hospital, Cincinnati—Obstetrics and gynecology 3; pathology 1.

Children's Hospital, Cincinnati—Pediatrics 16.

Christ Hospital, Cincinnati—Anesthesiology 1; internal medicine 4; neurological surgery 1; pathology 1; psychiatry 1; surgery 4.

Cincinnati General Hospital—Dermatology and syphilology 7; internal medicine 32; obstetrics and gynecology 3; ophthalmology 2; otolaryngology 2; orthopedic surgery 4; pathology 5; pediatrics 16; psychiatry 19; radiology 7; surgery 24.

Deaconess Hospital, Cincinnati—Internal medicine 1; surgery 1.

Good Samaritan Hospital, Cincinnati—Internal medicine 6; pathology 1; surgery 8.

Jewish Hospital, Cincinnati—Internal medicine 7; orthopedic surgery 1; pathology 1; radiology 1; surgery 8.

Dunham Hospital, Cincinnati—Pulmonary diseases 6.

St. Mary's Hospital, Cincinnati—Surgery 3.

Longview State Hospital, Cincinnati—Psychiatry 3.

City Hospital, Cleveland—Contagious diseases 4; dermatology and syphilolgy 3; internal medicine 18; obstetrics and gynecology 3; ophthalmology 2; otolaryngology 2; pathology 6; pulmonary diseases 2; radiology 4; surgery 18; thoracic surgery 2; urology 2.

Cleveland Clinic Foundation Hospital—Anesthesiology 4; dermatology and syphilology 3; internal medicine 21; neurological surgery 7; ophthalmology 3; otolaryngology 7; orthopedic

OHIO HOSPITALS APPROVED FOR INTERN TRAINING, WITH NUMBER OF INTERNSHIPS AVAILABLE AND OTHER PERTINENT DATA

	Control	Capacity	Total Patients Admitted	% Service Cases	Type of Internship	Internships	Affiliated Service	Outpatient Service	Autopsy Percentage	Stipend
City Hospital, Akron	NPA	418	16,047	7	R	15	(222)	Req	48	30
Peoples Hospital, Akron	NPA	210	9,526	5	R	6	(222)	Req	63	50
St. Thomas Hospital, Akron	Church	205	9,187	----	R	8	(223)	Req	42	75
Aultman Hospital, Canton	NPA	301	10,067	14	R	10	No	Req	46	50
Mercy Hospital, Canton	Church	229	10,432	----	R	6	No	Req	35	75
Bethesda Hospital, Cincinnati	Church	218	8,407	21	R	8	(224)	Req	62	75
Christ Hospital, Cincinnati	Church	370	11,027	15	R	16	(224)	Req	43	30
Cincinnati General Hospital	City	850	14,953	100	R-S	42	(225)	Req	57	----
Deaconess Hospital, Cincinnati	Church	168	4,827	15	R	5	(226)	Req	21	100
Good Samaritan Hospital, Cinci.	Church	538	16,431	5	R	18	No	Req	49	60
Jewish Hospital, Cincinnati	NPA	264	9,432	7	R	10	(227)	Req	54	50
St. Mary's Hospital, Cincinnati	Church	200	5,517	35	R	6	(228)	Req	44	75
City Hospital, Cleveland	City	1,075	12,863	100	R-S	24	No	Req	86	40
Evangelical Deaconess Hospital, Cl.	Church	132	6,834	----	R	3	No	Req	20	75
Fairview Park Hospital, Cleveland	Church	150	7,351	3	R	6	No	Req	40	75
Glenville Hospital, Cleveland	NPA	120	4,592	5	M	4	No	None	42	75
Mount Sinai Hospital, Cleveland	NPA	219	9,644	10	R	8	No	None	45	50
St. Alexis Hospital, Cleveland	Church	235	10,029	14	R-S	8	No	Req	34	50
St. John's Hospital, Cleveland	Church	234	8,830	12	R	9	No	None	35	----
St. Luke's Hospital, Cleveland	Church	237	14,044	14	R	20	No	Req	44	30
St. Vincent Charity Hospital, Cl.	Church	297	8,781	16	R	12	(229)	Req	42	50
University Hospitals, Cleveland	NPA	700	22,725	36	S	46	No	Req	65	Varies
Grant Hospital, Columbus	NPA	290	9,998	5	R	8	No	None	43	50
Mount Carmel Hospital, Columbus	Church	265	10,241	5	R	8	(230)	None	28	50
Ohio State University Hospitals, Col.	State	279	8,876	53	R-S	22	(231)	None	81	9
St. Francis Hospital, Columbus	State	161	4,158	64	R	7	No	None	55	----
White Cross Hospital, Columbus	Church	296	10,718	12	R	12	No	None	41	50
Good Samaritan Hospital, Dayton	Church	310	12,791	6	R-S	6	No	Req	14	----
Miami Valley Hospital, Dayton	NPA	425	13,752	10	R	10	No	Req	44	50
St. Elizabeth Hospital, Dayton	Church	335	15,245	12	R	6	No	Req	53	125
Huron Road Hospital, East Cleve.	NPA	277	10,717	----	R	11	No	Req	51	50
Mercy Hospital, Hamilton	Church	300	8,639	15	R	—	No	None	34	100
Lakewood Hospital, Lakewood	City	129	5,830	----	R	4	No	Req	55	75
Lima Memorial Hospital, Lima	NPA	165	6,330	5	R	6	No	None	24	90
St. Rita Hospital, Lima	Church	300	10,458	10	R	8	No	Req	23	100
Springfield City Hospital, Sp.	City	270	10,115	5	R	8	No	Req	43	100
Flower Hospital, Toledo	Church	135	5,256	----	R	6	No	None	29	150
Maumee Valley Hospital, Toledo	County	292	4,386	90	R	10	No	Req	58	75
Mercy Hospital, Toledo	Church	295	11,750	30	R	8	No	Req	47	100
St. Vincent's Hospital, Toledo	Church	310	10,656	----	R	2	No	Req	35	75
Toledo Hospital, Toledo	NPA	266	9,574	4	R	10	No	Req	53	75
St. Elizabeth Hospital, Youngstown	Church	320	11,585	----	R	10	No	Req	26	100
Youngstown Hospital, Youngstown	NPA	627	19,327	----	R	20	No	Req	40	25

In the above table, the following abbreviations are used: **NPA**—nonprofit association; **R**—rotating internship, which is defined as one which provides supervised experience in internal medicine, surgery, pediatrics, obstetrics and their related subspecialties, together with experience in laboratory and radiologic diagnosis; **S**—straight internship, which is defined as one which provides supervised experience in a single department, although it may include limited opportunity for work in a related subspecialty; **M**—mixed; **Reg**—required.

Key numbers under the heading "Affiliated Service" indicate the following affiliations: (222) Children's Hospital, Akron, pediatrics; (223) Edwin Shaw Sanatorium, tuberculosis, and Summit County Receiving Hospital, Cuyahoga Falls, psychiatry, (224) Children's Hospital, Cincinnati, pediatrics; (225) Dunham Hospital, tuberculosis, and Hamilton County Home and Chronic Disease Hospital, Cincinnati, chronic diseases; (226) Cincinnati General Hospital, contagious diseases, pediatrics; (227) Cincinnati General Hospital, pediatrics; (228) Cincinnati General Hospital, contagion; (229) St. Ann's Maternity Hospital, Cleveland, obstetrics; (230) Children's Hospital, Columbus, pediatrics; (231) Children's Hospital, St. Francis Hospital, Columbus, pediatrics, medicine.

Internships are for 12 months with the following exceptions: St. Mary's Hospital, Cincinnati, Mt. Sinai Hospital, Cleveland, Youngstown Hospital, each 12-24 months; University Hospitals, Cleveland, Ohio State University Hospital, Columbus, each 24 months.

surgery 7; pathology 8; physical medicine 1; psychiatry 2; radiology 10; surgery 13; urology 5.

Cleveland State Receiving Hospital—Psychiatry 13.

Cleveland State Hospital—Psychiatry 2.

Fairview Park Hospital, Cleveland—Obstetrics and gynecology 2; surgery 4.

Lutheran Hospital, Cleveland—Obstetrics and gynecology 2; radiology 3; surgery 7.

Grace Hospital, Cleveland—General residency 2.

Mt. Sinai Hospital, Cleveland—Anesthesiology 1; internal medicine 3; obstetrics and gynecology 3; orthopedic surgery 2; pathology 2; radiology 2; surgery 6.

St. Alexis Hospital, Cleveland—Internal Medicine 2; radiology 1; surgery 6.

St. Ann's Maternity Hospital, Cleveland—Obstetrics and gynecology 2.

St. John's Hospital, Cleveland—Internal Medicine 3; obstetrics and gynecology 3; surgery 4.

St. Luke's Hospital, Cleveland—Anesthesiology 1; internal medicine 5; obstetrics and gynecology

4; ophthalmology 1; otolaryngology 2; orthopedic surgery 2; pathology 2; radiology 3; surgery 4.

Sunny Acres, Cuyahoga County Tuberculosis Hospital, Cleveland—Pulmonary diseases 6.

St. Vincent Charity Hospital, Cleveland—Internal medicine 3; pathology 1; radiology 3; surgery 9.

University Hospitals, Cleveland—Dermatology and syphilology 3; Internal medicine 17; obstetrics 7; gynecology 7; ophthalmology 4; otolaryngology 3; orthopedic surgery 1; pathology 6; pediatrics 9; psychiatry 1; radiology 4; surgery 16; urology 1.

Grant Hospital, Columbus—Pathology 1.

Mt. Carmel Hospital, Columbus—Internal medicine 2; orthopedic surgery 1; surgery 1.

Children's Hospital, Columbus—Orthopedic surgery 2; pediatrics 11.

Franklin County Tuberculosis Hospital, Columbus—Pulmonary diseases 5.

Columbus State Hospital—Psychiatry 3.

St. Ann's Maternity Hospital, Columbus—Obstetrics and gynecology 2.

St. Francis Hospital, Columbus—Internal medicine 2; surgery 3.

Ohio State University Hospital, Columbus—Anesthesiology 3; internal medicine 13; obstetrics and gynecology 6; ophthalmology 4; otolaryngology 1; pathology 4; radiology 4; surgery 18; urology 3.

White Cross Hospital, Columbus—Internal medicine 3; obstetrics and gynecology 3; orthopedic surgery 2; pathology 2; surgery 5.

Miami Valley Hospital, Dayton—Internal medicine 3; obstetrics and gynecology 1; pathology 1; radiology 2; surgery 4.

Huron Road Hospital, East Cleveland—Anesthesiology 5; internal medicine 2; pathology 1; surgery 7.

Mercy Hospital, Hamilton—Surgery 3.

Lakewood Hospital, Lakewood—Anesthesiology 1; internal medicine 2; obstetrics and gynecology 1; surgery 3.

Mansfield General Hospital, Mansfield—Anesthesiology 2; general residency 2.

Massillon State Hospital, Massillon—Psychiatry 3.

Maumee Valley Hospital, Toledo—Anesthesiology 1; internal medicine 3; obstetrics and gynecology 2; surgery 4.

Mercy Hospital, Toledo—Internal medicine 1; obstetrics and gynecology 4; pathology 1; surgery 4.

St. Vincent's Hospital, Toledo—Internal medicine 1; neurological surgery 1; obstetrics and gynecology 1; orthopedic surgery 2; radiology 1; surgery 3; urology 2.

Toledo Hospital—Internal medicine 3; obstetrics and gynecology 3; pathology 2.

Harding Sanitarium, Worthington—Psychiatry 3.

Mahoning Tuberculosis Sanitorium, Youngstown—Pulmonary diseases 3.

St. Elizabeth Hospital, Youngstown—Internal medicine 2; obstetrics and gynecology 2; surgery 6.

Youngstown Hospital—Anesthesiology 1; internal medicine 6; orthopedic surgery 1; pathology 3; proctology 1; radiology 2; surgery 8.

Veterans Administration Hospital, Brecksville—Pulmonary diseases 3; thoracic surgery 1.

Veterans Administration Hospital, Cleveland—Internal medicine 27; neurological surgery 1; ophthalmology 2; otolaryngology 2; orthopedic surgery 7; pathology 1; psychiatry 11; radiology 4; surgery 18; urology 2.

Veterans Administration Hospital, Dayton—Internal medicine 24; surgery 15.

U. S. Marine Hospital, Cleveland—Surgery 1.

Examinations for Veterans' Disability Claims

The National Rehabilitation Commission of the American Legion suggests some ways through which physicians can help veterans accomplish disability claims.

The Veterans Administration regulations require that the physician's statement be notarized only in initial establishment of service connection for a specific disease or condition.

Most doctors will be examining and working on reports for veterans who have already had service connection established, and are conducting the examination to determine whether the condition has improved, regressed or remained stationary. In such cases the statement on the physician's letterhead is sufficient.

The doctor should state in the body of his report whether the information is from his office or clinic records, or from memory.

Reports should be in professional language and as complete and detailed as possible.

Date of first treatment and length of time the veteran has been observed should be included. Details of the pertinent history and physical examination are essential. Detailed medical findings, both physical and laboratory, should be included.

Congress of Physical Medicine

The American Congress of Physical Medicine will hold its 27th annual scientific and clinical session September 6-10 at the Netherland Plaza Hotel, Cincinnati. All sessions will be open to members of the medical profession in good standing with the American Medical Association. Full information may be obtained by writing to the Congress at 30 N. Michigan Ave., Chicago 2, Ill.

Ohio Hospitals . . .

A. M. A. Annual Survey Shows Interesting Information on Local Facilities, Number of Beds, Patients Admitted and Other Data

THE number of patients admitted to registered hospitals during 1948 reached an all-time high, according to the annual presentation of hospital data by the Council on Medical Education and Hospitals of the American Medical Association in the May 7 issue of the *Journal of the A.M.A* .

The number admitted to hospitals in 1948 was 16,422,774, compared to the previous record of 16,257,402 reached in 1945. The number of beds in approved hospitals has declined consistently since 1945, but this decline has been counteracted by the decrease in the average length of stay of patients.

In nongovernmental hospitals, the length of stay declined from an average of 8.7 days in 1947 to 8.2 days in 1948. In governmental hospitals the length of stay in 1948 varied from 10 days in city-county hospitals to 27.9 days in the Federal classification.

The number of births in hospitals declined somewhat from the all-time high of 1947, but remained high with 2,794,281.

The survey shows an appreciable increase in nursing personnel in hospitals as compared with 1947. The number of graduate nurses, exclusive of private duty nurses employed in hospitals increased from 167,354 to 196,120, the full-time general duty nurses from 86,218 to 104,041 and the practical nurses and attendants from 119,746 to 141,834.

OHIO HOSPITALS

A breakdown of hospital facilities in Ohio is as follows:

Federal Hospitals 7; beds 4,898; bassinets 3; patients admitted 20,427; average census 4,498.

State Hospitals 27; beds 32,970; bassinets 37; patients admitted 28,636; average census 31,170.

County Hospitals 27; beds 3,996; bassinets 127; patients admitted 23,156; average census 3,448.

City Hospitals 19; beds 3,253; bassinets 390; patients admitted 74,559; average census 2,561.

City-County Hospitals 1; beds 78; bassinets 22; patients admitted 4,169; average census 71.

Total Governmental Hospitals (a summary of the preceding) 81; beds 45,195; bassinets 579; patients admitted 150,947; average census 41,748.

Church related (nonprofit) 46; beds 8,221; bassinets 1,445; patients admitted 293,106; average census 7,112.

Nonprofit associations 95; beds, 10,128; bassinets 1,865; patients admitted 351,151; average census 8,252.

Total nonprofit (summary of preceding two classifications) 141; beds 18,349; bassinets 3,310; patients admitted 644,257; average census 15,364.

Individual and Partnership 11; beds 450; bassinets 28; patients admitted 7,095; average census 327.

Corporation 7; beds 519; bassinets 4; patients admitted 2,567; average census 456.

Total proprietary (summary of preceding two classifications) 18; beds 969; bassinets 32; patients admitted 9,662; average census 783.

Total nongovernmental (summary of preceding nongovernmental) 159; beds 19,318; bassinets 3,342; patients admitted 653,919; average census 16,147.

Grand Total of all hospitals in Ohio (summary of the preceding) 240; beds 64,513; bassinets 3,921; patients admitted 804,866; average census 57,895.

TYPE OF SERVICE

Following are the number of hospitals in Ohio and number of beds according to type of service offered: General 151 with 23,568 beds; nervous and mental 27 with 34,426 beds; tuberculosis 23 with 3,344 beds; maternity seven with 194 beds; industrial one with 18 beds; children's three with 530 beds; orthopedic three with 134 beds; convalescent and rest nine with 460 beds; hospital departments of institutions 12 with 987 beds; all other hospitals four with 852 beds; total 240 with 64,513 beds.

NURSING PERSONNEL

The survey shows the following nursing personnel and schools of nursing in Ohio: Student nurses 5,397; accredited schools of nursing, 61; schools offering affiliating courses only 9 with 373 students; administrative nursing personnel 389; full-time instructors 310; supervisors and assistant supervisors 937; head nurses and assistant head nurses 1,456; general duty nurses full time 4,718 and part time 1,333; nurses not classified 172; total graduate nurses 9,315; private duty nurses 1,678; practical nurses and attendants 7,596; volunteer nurses' aides 1,193; orderlies 1,324; ward maids 2,491.

In 1900, 64 per cent of all the reported tuberculosis deaths took place in the 15-44 age group. Only 24 per cent of those who died were over 45. In 1947, 52 per cent of all those who died of tuberculosis were over 45. The number of deaths in the "vulnerable" ages, 15-44, had fallen to 45 per cent of the total, according to *Public Health Reports.*

Miners' Medical Care Plan . . .

Ohio Physicians Asked To Participate in Expanded U. M. W. Program; Details of How It Will Operate Furnished by Area Medical Office

OHIO physicians, hospital authorities, and druggists in counties where members of the United Mine Workers of America reside or work are being requested to participate in the expanded medical care program of the U. M. W. which is being financed from the Welfare and Retirement Fund of the organization.

Following is the text of a letter which has been sent to physicians in the coal mining counties of the state by Dr. Leslie A. Falk, Pittsburgh, medical administrator for the area covering Ohio, the northern panhandle counties of West Virginia, and the western counties of Pennsylvania:

TEXT OF LETTER

"The United Mine Workers Welfare and Retirement Fund is now providing for home and office care, hospitalization, drugs, and specialist services for miners and their dependents receiving Pensions, Disability Benefits, or Widow's Assistance from the Fund. At present, such services must be authorized in advance by the Fund's Area Medical Administrator. The Fund would like to make arrangements which will eliminate the necessity for this advance authorization for the care of each patient.

"A plan has been developed whereby United Mine Worker members receiving Pensions, Disability Benefits, or Widow's Assistance will be able to identify themselves and their dependents as eligible for medical care, and thus eliminate the need for prior authorization.

"In addition, the Fund plans to broaden its medical care program to provide hospitalization and medical care in the hospital for all other members of the United Mine Workers of America not covered by hospital check-off. As soon as the necessary arrangements are completed, these plans will be put into effect.

"In an effort to complete these arrangements, we are writing you to determine your willingness to provide care for these patients. Payment for service provided will be on a fee-for-service basis. Patients will have free choice of those physicians with whom an agreement has been reached. The physician will likewise have the freedom of accepting or refusing to care for the individual patient. The physician will have the opportunity to refer the patient for such specialist services as are needed.

"The purpose of this letter is to ascertain your willingness to care for these patients on a basis satisfactory to you and the Fund. We will appreciate it if you will complete the attached questionnaire and return it to us.

"We will welcome any suggestions which you may wish to make."

Dr. Falk's communication was accompanied by a questionnaire on which the physician is being asked to indicate whether he would be willing to participate and which asks the physician to supply certain factual data.

ENDORSED BY A. M. A.

The U. M. W. medical care program is in line with the recommendations of a medical advisory board on which the American Medical Association is represented. The program has the endorsement of the Council on Industrial Health of the American Medical Association, confirmed by the House of Delegates of the A. M. A. at its December, 1948, meeting in St. Louis. The executive medical officer of the fund is Dr. Warren F. Draper, former deputy surgeon general of the U. S. Public Health Service, and for many years a member of the House of Delegates of the A. M. A.

Several conferences between representatives of the Ohio State Medical Association and Dr. Falk have been held. The Council of the Ohio State Medical Association has taken no official action on the U. M. W. program, other than to assure U. M. W. officials of a desire to cooperate on matters of policy and administration.

The question of participating in the program is one which each physician should answer for himself after understanding fully the objectives of the program and how it will operate. Following are a number of important points of the revised program which should be weighed by physicians who are being asked to participate:

TEN IMPORTANT POINTS

1. Payment for services will be on a fee-for-service basis.
2. There will be no single fee schedule applying to all areas. Physicians will be expected to bill the Fund in accordance with the customary fees charged patients in the same economic status as the miner who is a beneficiary of the Fund. The Fund will not pay what it may consider unreasonable fees.
3. Beneficiaries of the Fund will have the free choice of those physicians who agree to participate.
4. A participating physician will have the freedom of accepting or refusing to care for a beneficiary.
5. Specialist service will be paid for by the Fund upon referral from the general practitioner.
6. In most instances the physician will not have to obtain prior authorization to render services.
7. A method by which the beneficiary

must identify himself and his eligibility to receive services has been established.

8. The forms used will be brief and uncomplicated.

9. Prescribing of drugs when indicated will be permitted.

10. Arrangements have been worked out for hospitalization and consultations when needed.

DETAILS OF PROGRAM

When asked by *The Ohio State Medical Journal* to explain in detail how the program will operate, Dr. Falk submitted the following information which amplifies the 10 points listed above:

As now operating, the Fund's program constitutes primarily an arrangement mechanism. It has no hospital facilities and no clinical personnel of its own. Reliance is placed on existing resources to meet the needs.

The program provides for "free choice." All physicians wishing to participate are eligible to do so, provided they are in good standing in the profession and have the confidence of the organization whose members they are to serve.

THOSE ELIGIBLE

Payment for medical care has been provided for members and dependents who are receiving benefits from the United Mine Workers of America Welfare and Retirement Fund. These are:

1. Miners and their families who are receiving disability benefit awards from the Fund (for non work-connected disabilities of thirty days or longer).

2. Miners and their families who are receiving miners' pensions from the Fund (aged 60 or over with 20 years in the mines, and at work as of May 29, 1946).

3. Widows and their families who are receiving widow's assistance from the Fund.

Three additional groups are provided medical care as follows:

4. Miners and their families who would be receiving disability benefits if they did not have some income from workmen's compensation, veterans' benefits, or the like.

5. Miners and their families who are unable to secure medical care they need because of the absence of specialists in the area in which they live.

6. Hospitalized illness payment for all soft coal mine union members and their dependents not covered by hospitalization "check-off" arrangements.

THOSE NOT ELIGIBLE

The Fund does not provide payment for services to which its eligibles are entitled under workmen's compensation, tax supported, voluntary prepayment, or other similar legal or contractual entitlements, except to supplement those medical services not covered.

During the first phase of the general medical care program, payment was authorized on a form issued by one of the Area Medical Offices of the Fund to the physician and hospital. The Fund was unable to pay retroactive medical bills, the program at this stage being a "prior authorization" program. Accordingly, no physician could accept as final authority a statement that an applicant's medical care would be paid for by the Fund unless the commitment emanated from the Fund or the Union's District Office, although eligibles knew their entitlement in most cases.

The program was limited at first to major medical care such as hospitalization, including surgery and specialized services. It did not cover day-to-day minor illnesses, home and office care, health examinations and preventive services. Nursing and dental services, drugs, appliances, and other related services could be authorized, but these required the prior recommendation of the attending physician.

REVISED PLAN NOW IN EFFECT

A simplification of the Fund's processes has now been instituted. Instead of having to obtain the commitment of the Fund that it will pay for a specific service for each case, a more general type of agreement is being made. From the returns of letters being sent to physicians in the areas served by the Fund, asking them to signify their willingness to bill the Fund instead of the patient for services for eligible beneficiaries, and whether they limit their practices or not, it will be possible to inform beneficiaries which physicians are willing to care for them at the expense of the Fund.

Specialist service is paid for by the Fund on referral from the general practitioner.

The physician is being informed how the patient will establish his identity as an individual eligible to receive medical care. The non-working patient must present his pension or disability benefit award statement, together with his latest Fund check stub to show that the award is still active. The working member will show a slip certified by his local union. Any questions on eligibility can be clarified by the Local or the District U. M. W. A. Offices.

DRUGS AND HOSPITALIZATION

Prescribed drugs can be provided to eligible patients, and use of a special prescription and referral blank, which is supplied, is preferred.

Hospitalization, consultations, and other referrals can also be arranged by the family doctor on these blanks.

Dental and eye care for cases referred by physicians in connection with medical treatment

can be provided. Estimates of their cost are required before the Fund will commit itself to assume these particular obligations.

General practitioners will maintain a register of the Fund's patients for reporting visits. Hospitalized cases will be reported on a separate invoice for each patient.

DISABILITY EXAMINATIONS

In addition to the medical care provided by the Fund's program, general practitioners may be asked by miners to examine them to determine the extent of their disabilities which may entitle them to cash payments from the Fund. A list of physicians to do such examinations is being compiled.

These examinations are now at the miner's own expense, except that the Fund will soon begin to pay for any specialist referrals, X-ray, laboratory, or any other expensive procedures incident to such examination when these receive prior authorization. The honest opinion of the examining physician is required if this mechanism is to work. Neither the Fund nor the Union's District Office will countenance a miner's receiving disability benefits when he is not entitled to them. The true facts must be presented in any questionable case.

OLD AGREEMENTS STILL IN EFFECT

The Fund does not alter immediately any of the existing "check-off" or other prepayment agreements for physician's home and office care as now exist in the mining areas. The Fund is expected ultimately to bear the full expense of hospital and medical services for the members, but this is a development which will come only with time and through the availability of funds.

Concluding his explanation, Dr. Falk said: "It is the purpose of the Fund to assist in the provision of high quality medical care. We are proceeding in good faith upon the assumption that members of the medical profession throughout the country will cooperate in furnishing a high quality of medical service at as reasonable cost as a similar quality could be obtained under any other system which could be devised. The advice, assistance and participation of the medical profession of Ohio is needed to insure the success of this program. It has already made an auspicious beginning, and is establishing a pattern for the future. The beneficial potentialities are vast, and some are already being realized."

Although 80 per cent of the population rate cancer as one of the most dangerous diseases they know, approximately half the American people do not know any cancer symptoms, and only three per cent know four or more, according to the American Cancer Society.

Activities of The Editor

Dr. Jonathan Forman, Editor of *The Journal*, on May 22-23, was in Lexington, Ky., where he attended the Annual meeting of the American Association of History of Medicine, of which organization he completed a year as treasurer and member of the executive committee. While in Lexington, he spoke before a meeting of the Kentucky Bacteriologic Society.

Other recent activities in which Dr. Forman took part include the following:

He spoke before "The D. A. Club" of Columbus, an organization of persons in central Ohio who are employees of the Department of Agriculture.

He addressed G-I vocational agricultural students of Pickaway County on the subject of rural health.

He spoke before the Mt. Vernon Child Conservation League on the subject of "Allergy and Your Child."

Dr. Forman handled all of the publicity and public relations activities for the convention of the American College of Allergists in Chicago in April. He attended meetings of the Board of Directors and the Board of Regents and was inducted into the presidency of the College at the meeting.

At a mass meeting of citizens of Dover and New Philadelphia sponsored by the Dover Chamber of Commerce, he spoke on "Soil Conservation."

He participated in a panel discussion on the topic of human needs at Ohio State University.

Before the Franklin County Historical Society, he presented a paper on the subject of the first cholera epidemic in Columbus, 1833.

He gave the principal address at the past-presidents' luncheon of the Cleveland Dental Society during the organization's annual clinics.

On May 8, he acted as leader in the workshop on education of the public in matters of health as part of the 19th Annual Institute for Education by Radio.

Dr. Forman was a guest of the Trustees of the Ohio State University as one who had served on the faculty of the University for 36 years.

At a dinner meeting held on the Ohio State University campus, he addressed a group of life insurance-farm loan men.

He attended the spring meeting of the Ohio Valley Society of Allergists.

General health conditions in the United States have improved to an extraordinary extent in recent years despite depression and war, according to "Health Progress 1936 to 1945," newly published by the Metropolitan Life Insurance Company as a report upon the mortality experience among the company's industrial policyholders.

Recent A.M.A. Session . . .

Historical Action Taken by House of Delegates at Atlantic City; Positive, Aggressive Policies Approved on Important Current Issues

THE 1949 Annual Session of the American Medical Association, held in Atlantic City the first week in June, may go into the records as one of the most historical sessions ever held by the association.

As usual the A. M. A. lived up to its record of presenting the world's largest and finest medical convention. Thousands of general practitioners and specialists from coast to coast and from the Great Lakes to the Gulf swarmed to Atlantic City to attend the outstanding scientific sessions and to tour the Scientific Exhibit which was bigger and better than ever.

Attendance of fellows alone was estimated at 13,200, to say nothing of the thousands of members of their families and interested laymen who were on hand for conferences, special meetings or solely social reasons. Approximately 400 Ohio physicians registered. Total number of persons registered was about 31,000.

MADE HISTORY

However, in the opinion of many, the 1949 session made history because of the positive, constructive and progressive actions—even sensational actions at times—of the House of Delegates at a time when the association is under intense fire, from without and within, on matters involving the social, economic and legislative aspects of medical and health services.

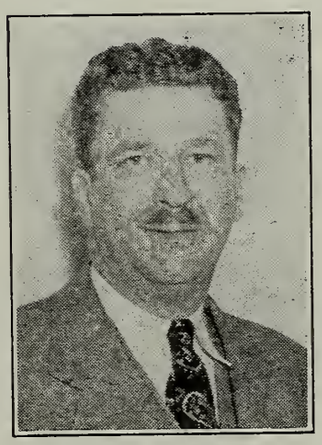
The public relations of the association were handled in excellent fashion before, during, and after the session. There were no "executive" sessions. The press and radio were admitted to all sessions. Press conferences were handled in a forthright manner.

Doubletalk in reports and statements approved by the delegates was conspicious by its absence. The House of Delegates met controversial issues head-on. Through its actions it proved that the medical profession is, and can be, as positive as others in wanting to find the solutions for the nation's medical and health problems. At the same time the House of Delegates clearly indicated that it was unwilling to sell the people and the medical profession down the river for expediency's sake or to satisfy the whims of a few hungry politicians. It demanded and supported action, but action which would insure only good medical care and health services.

Official representatives of the Ohio State Medical Association took a leading part in the transactions of the House of Delegates. Three of Ohio's delegates were members of reference committees, namely: Dr. L. H. Schriver, Cincinnati, Rules and Order of Business; Dr. William M. Skipp, Youngstown, Reports of Boards of Trustees and Secretary; and Dr. Carl A. Lincke, Carrollton, Credentials.

LINCKE HONORED

Dr. Lincke, current president of the Ohio State Medical Association, was accorded a high honor at the session by being elected a member of the Council on Scientific Assembly which arranges the programs for the general sessions at the annual and interim sessions of the A.M.A. and works with the section officers on the section programs. Dr. Lincke was named as a representative of general practice which is specified in the By-Laws.



C. A. LINCKE, M. D.

Other Ohio delegates in attendance were: Dr. George A. Woodhouse, Pleasant Hill; Dr. Frank M. Wiseley, Findlay; Dr. Edgar P. McNamee, Cleveland; Dr. C. C. Sherburne, Columbus; and Dr. A. A. Brindley, Toledo. Dr. Paul A. Davis, Akron, was a delegate, representing the Section on General Practice and he served on the reference committee on Insurance Plans and Medical Service.

Dr. Edward J. McCormick, Toledo, a member of the Board of Trustees of the A. M. A., was active in the House of Delegates sessions. After his appointment as deputy director of the newly unified medical services of the armed forces had been announced by Defense Secretary Louis Johnson, Dr. Richard L. Meiling, Columbus, was introduced to the House of Delegates. Dr. Meiling will become director of the medical services after serving three months as deputy director. He is an alternate delegate from Ohio to the A. M. A. House of Delegates and a member of the Council on National Emergency Medical Service of the A. M. A.

HIGHLIGHTS OF ACTIONS

A detailed review of the actions of the House of Delegates cannot be presented in this issue. Reports on some of the important transactions

will be published later, when the text of the resolutions and reports are available. However, following are high spots of the five sessions of the House of Delegates:

1. Approval of the 12-Point Program of the American Medical Association, drafted by the Board of Trustees several months ago, with supplemental statements elaborating on the 12 points and making definite statements regarding specific pieces of pending national legislation.

ACTION ON A. M. C. P.

2. Approval of a recommendation of the Council on Medical Service that there should be complete and absolute separation of Associated Medical Care Plans (Blue Shield Plans national organization) from the American Medical Association. This leaves the responsibility for the activities and actions of A. M. C. P. in the hands of the member medical care plans all of which are controlled and sponsored by local, district, or state medical societies.

The action stated that the Council on Medical Service would continue to approve or disapprove all voluntary medical care plans, whether A. M. C. P. plans or not; would continue to promote the principle of voluntary insurance to the public; and would continue to stimulate active interest on this question among members of the medical profession.

The formation of a national coordinating agency representing all qualified voluntary prepayment plans was recommended.

In another resolution which was adopted, the House of Delegates approved the formation of a national enrollment agency, which might even be a national insurance company to be organized by A. M. C. P., with the understanding that such a company would be controlled by the medical care plans and would have to meet specific requirements to obtain approval of the Council on Medical Service.

There was a general impression that these actions solved a problem on which there had been violent disagreement during the past year and that all parties concerned were satisfied with the proposal which had been worked out.

TWENTY PRINCIPLES ADOPTED

3. The House of Delegates ratified 20 principles which lay-sponsored voluntary health or medical care plans must meet to obtain approval from the Council on Medical Service. They were drafted by that agency following extensive conferences with representatives of consumer groups, labor and farm organizations, and others.

The principles were set up as a guide for approval or disapproval of such plans by the Council on Medical Service and to assist physicians who are asked to participate in such plans.

It was pointed out that at present there are approximately 170 lay-sponsored voluntary health plans in operation, serving about 1,600,000 persons, and that the formation of such plans is becoming an important factor in collective bargaining between groups of employees and employers.

4. The House of Delegates also approved another recommendation of the Council on Medical Service that it work closely with Whitaker and Baxter, the public relations firm now conducting the National Educational Campaign for the A. M. A., in developing the positive and affirmative aspects of the campaign.

It was pointed out that this had the full approval of Whitaker and Baxter and that the trend of the national campaign during the ensuing months will stress the 12-point program of the A. M. A. and tell the people what the medical profession stands for, what it has accomplished, and more about the benefits and advantages of the voluntary prepayment medical and hospital care plans.

FISHBEIN RETIREMENT?

5. A statement from the Board of Trustees regarding the status and future activities of Dr. Morris Fishbein, editor, *The Journal of the American Medical Association*, and intimating that early retirement of Dr. Fishbein may be anticipated, was adopted by the House of Delegates. The text of the Board's statement on this matter read as follows:

"The Board of Trustees is aware of the criticism of the Editor coming from within and from without the profession. The Board recognizes that the public has come to believe that the Editor is spokesman of the Association. The membership undoubtedly wishes the elected officials to speak authoritatively on all matters of medical policy.

"Against the time when the Editor retires Dr. Austin Smith has for some months been in training as the Assistant Editor and the talent of the Editor will be retained for the present under the control of the Board of Trustees.

"In view of the increasing responsibility of the Editor and reorganization of the department, the Board of Trustees has decided on the following points:

"1. The Editor will completely eliminate speaking on all controversial subjects both by platform and by radio. Approval of all speaking engagements will be made by the Executive Committee.

"2. Elimination of all interviews, including press conferences, and statements by Doctor Fishbein except on scientific subjects.

"3. Editorials on controversial subjects will be supervised by the Executive Committee.

"4. Complete information as to these activities will be reported to the members of the House of Delegates.

"5. There will be permanent elimination of diary in Tonics and Sedatives.

IF YOU WANT CAMPAIGN LITERATURE FOR YOUR PATIENTS AND OTHERS, WRITE THE COLUMBUS OFFICE

The Columbus Office of the Association is prepared to furnish various kinds of educational campaign pamphlets and folders to members or those outside the medical profession.

Just drop that office a card. Let it know how much you can use. There will be no charge. Literature can be supplied in any quantities desired.

The campaign to educate the people about what the medical profession stands for and why radical pending proposals in Congress should be defeated has made a good start. It should not bog down during the summer. Keep firing. The folders are yours for the asking.

"6. Plans for the training of a new Editor in an orderly manner, including the retirement of the present Editor, will be formulated.

"The Board of Trustees of the American Medical Association announces that plans have been formulated for the retirement of Dr. Morris Fishbein as Editor of *The Journal of the American Medical Association* at an appropriate time. For thirty-seven years, Dr. Fishbein has served the A. M. A. well and faithfully. *The Journal of the A. M. A.* is an enduring monument to his genius and devotion. His activities have extended far beyond his immediate duties as an editor and the Board desires to pay tribute to his many accomplishments in other fields.

"The Board finds that serious dislocation would result from any sudden replacement. With this in mind, a reorganization of the editorial staff is underway so that his retirement, when consummated, will not result unfavorably for ventures of the Association."

Unofficial reports circulated at the session intimated that Dr. Austin Smith, secretary of the Council on Pharmacy and Chemistry, is being groomed to succeed Dr. Fishbein upon the latter's retirement. These reports also intimated that Dr. W. W. Bauer, director of the Bureau of Health Education, would become editor of *Hygeia*, and that Dr. Richard J. Plunkett, now assistant editor of *The Journal of the A. M. A.*, would take over supervision of the association's nine specialized journals.

ADVOCATE UNIFIED MEMBERSHIP

6. Adoption of a resolution presented by Dr. Lincke, on behalf of the Ohio delegates and the Ohio State Medical Association, requesting amendments to the Constitution and By-Laws of the A. M. A. to provide for the elimination of the "fellowship" classification of membership and for but one type of membership. The resolution as approved, requested that the Board of Trustees prepare the proper amendments and submit them to the House of Delegates for action at the earliest appropriate time. Action cannot be taken before the A. M. A. annual session in 1950.

7. The Committee on Hospitals and the Practice of Medicine submitted a lengthy report setting forth certain basic principles on the question of the practice of medicine by hospitals. It recommended that hospitals violating the principles should be liable for removal from the approved list of hospitals of the A. M. A. This report, with some amendments by the reference committee, was approved by the House of Delegates. Appended to the report was a study of the various state laws on corporate practice of medicine and of court decisions and opinions of attorneys general on this matter.

8. One of the outstanding actions taken was that, instructing the Board of Trustees to arrange for a nation-wide conference of representatives of the medical profession, other health professions, hospitals, labor organizations, farm groups, government, industry, and other groups and organizations for the purpose of discussing the A. M. A. 12-point program and endeavoring to arrive at an understanding on the matter of developing a better health program for the nation. It was indicated such a conference would be held some time during this summer.

9. A resolution was adopted endorsing in principle those features of S. 1581, the Taft Bill, and S. 1456, the Hill Bill, both relating to the development of a so-called "voluntary" national health program without compulsory features, which are consistent with the A. M. A. policies set forth in its 12-point program. The Board of Trustees was instructed to confer with the authors of the two bills in an effort to draft a measure containing the acceptable features of both bills and the Board was requested to support a composite bill of that kind if agreements can be reached.

In this action, and in other actions, taken by the House of Delegates, it was emphasized that the A. M. A. should continue to oppose the compulsory sickness insurance features of S. 1679, the Thomas-Murray-Wagner Bill, and similar measures.

10. Revisions of the Principles of Medical

FEE INCREASES APPROVED BY INDUSTRIAL COMMISSION

Increases in the Workmen's Compensation Medical Fee Schedule, recommended by The Council and the Committee on Industrial Health and Workmen's Compensation of the Ohio State Medical Association, were approved by the Ohio Industrial Commission on June 20, and will become effective July 1.

The increased fees, which will be of importance to general practitioners and others doing office industrial practice, are as follows:

First treatment at office (day), $5.00;

First treatment at home or hospital (day), $7.00;

First treatment at office, home or hospital (night emergency between 10:00 P. M. and 7:00 A. M.), $9.00;

Subsequent treatment at office, including ordinary medication and dressings, $3.00;

Subsequent treatment at home, including ordinary medication and dressings, $4.00;

Subsequent treatment at hospital, $3.50;

Repair of tendon (finger): Flexor tendon, $75.00; extensor tendon, $50.00; each additional tendon, $25.00; maximum fee for repair of tendons, $150.00.

Ethics, recommended by the Judicial Council, were approved. These revisions clarified certain portions of the code of ethics and added more "teeth" in some of the sections.

11. By unanimous action, the House of Delegates elected Dr. Elmer L. Henderson, Louisville, Ky., retiring chairman of the Board of Trustees, as president-elect. He will take the office of president in 1950. Dr. Ernest E. Irons, Chicago, took over the presidency for the ensuing year from Dr. R. L. Sensenich, South Bend, Ind.

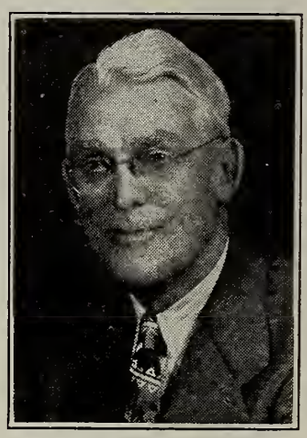
EDUCATION PROGRAM APPROVED

12. A detailed analysis of the activities of Whitaker and Baxter, public relations representatives in charge of the National Educational Campaign, was presented by the Board of Trustees. The report, which shows that remarkable progress is being made in presenting medicine's story to the people and in securing endorsements of the A. M. A. action in opposing compulsory sickness insurance, was adopted by the House of Delegates and a vote of confidence given to the work of Whitaker and Baxter.

Immediately prior to the opening of the A. M. A. session, the Grass Roots Conference for presidents and secretaries of county medical societies and the Conference of Presidents of State Medical Societies were held. These were well attended and interesting programs presented. On Wednesday of the week of the A. M. A. meeting there was a meeting of the Medical Society Executives Conference, the membership of which is made up of paid executives of local, state and national medical societies. This was attended by Charles S. Nelson, executive secretary, and George H. Saville, assistant executive secretary, of the Ohio State Medical Association. Mr. Nelson presided over the conference as chairman, having been elected in 1948. He will be succeeded as chairman by James Bryan, executive secretary of the New Jersey State Medical Society.

After 14 Years With General Motors, Dr. Selby Retires

Dr. Clarence D. Selby, formerly of Toledo and a past-president of the Ohio State Medical Association, after 14 years as General Motors medical consultant with offices in Detroit, is retiring effective July 1 at the age of 71.



C. D. SELBY, M. D.

Dr. Selby pioneered in the establishment of General Motors' industrial hygiene section, which, according to company officials, has virtually eliminated illnesses caused by fumes, vapors and dusts. He was instrumental in developing G. M.'s selective placement program through which persons with physical impairments can be placed in productive jobs.

During his period with the firm, medical facilities in the plants have been expanded and modernized with more than 100 doctors and 500 nurses and laboratory technicians.

Last year Dr. Selby inaugurated a cooperative program between G. M. and medical schools whereby graduates interested in industrial medicine are able to take their internship in G. M. plants.

Dr. Selby was president of the Ohio State Medical Association in 1925-26 and its secretary for a period prior to World War I. He served as chief-of-staff of St. Vincent's Hospital and commissioner of health of Toledo. He left Toledo in 1935.

In 1942 he received the American Association of Industrial Physicians and Surgeons' annual William S. Knudsen Award for the "most outstanding contribution to industrial medicine for the year 1941-42."

Barbiturate Control Law . . .

Measure Passed by Present Legislature To Become Effective August 12; Provisions of Act of Special Interest to Physicians Are Analyzed

HOUSE BILL 308, to regulate the handling, sale, and distribution of barbiturates in the State of Ohio, which was passed on May 5 by the Ohio General Assembly and signed by Governor Lausche on May 12, **will become a law on August 12, 1949.**

This measure was jointly sponsored by the Ohio State Medical Association and the Ohio State Pharmaceutical Association for the purpose of setting up proper and reasonable controls over the sale or distribution of barbiturates. It provides an orderly method of meeting a problem which has become very serious throughout the state wherein persons have been able to secure barbiturates indiscriminately, without the advice and supervision of a physician. This practice has caused many cases of impaired mental and physical health and has even led many to commit suicide or acts of violence upon others.

The proposal was introduced in the House of Representatives by Representative Morton C. Anderson, Columbus, and was co-sponsored in the Senate by State Senator Richard A. Wilmer, Hamilton, both of whom did an excellent job of steering the measure through the health committees of both bodies and of leading the debate in favor of the bill on the floor of each house.

The provisions of the act which are of special interest to all physicians of Ohio are as follows:

PRINCIPAL PROVISIONS

1. Each physician who has barbiturates on hand for dispensing or administering to patients **must make a record (inventory)** of them as of the effective date of the act (August 12) and must retain such record **for not less than two calendar years.**

The same provision applies to pharmacists and others legally possessing barbiturates for re-sale or delivery, except carriers.

2. Each physician must retain for at least **two calendar years,** each commercial or other **record on the purchase** of barbiturates (invoice) for his office supply.

The same provision applies to others making purchases for use or re-sale.

3. A physician is required to keep a record in some cases where a barbiturate is administered, dispensed or professionally used; in others no record is required.

When a physician administers, dispenses or professionally uses a barbiturate in the treatment of a patient **he must keep a record if the amount exceeds 12 grains in any 48 consecutive hours.**

When the amount for a single patient is 12 grains or less in 48 consecutive hours, **no record keeping is required by the new law.**

In cases where a record is required, the record must be kept on file for at least two calendar years after the last administering, dispensing or professional use.

The record to be kept where the amount of barbiturate exceeds 12 grains must show the name and address of the patient and the amount administered, dispensed or professionally used.

4. When a physician dispenses barbiturates to a patient, the container in which the barbiturate is placed (envelope or box) must bear a label on which appears the name and address of the physician, the name and address of the patient, and directions for the use of the barbiturates.

5. All sales by pharmacists must be on prescription. There is no restriction on the amount of barbiturate which a physician may prescribe.

6. **No prescription can be refilled by a pharmacist unless the prescribing physician so designates on the prescription.**

7. All records required must be made available on request to officers or employees duly designated by the State Board of

Inasmuch as the cooperation of all physicians and pharmacists will be necessary to make the new barbiturate control law effective and of public benefit, it is suggested that County Medical Societies and local organizations of pharmacists arrange for joint conferences at which provisions of the law can be discussed and plans be made for real cooperation between the two professions on this matter.

Much good could be accomplished through a thorough understanding of the responsibilities of both professions and how they should work together in carrying out the provisions of the act—at least misunderstandings can be avoided through such conferences.

Pharmacy to make inspections. The pharmacy board is the administrative and enforcement agency specified by the act.

8. Anyone violating any provision of the act is subject to a fine not exceeding $500, or to imprisonment for not more than one year, or both such fine and imprisonment.

COMPLETE TEXT OF LAW

The complete text of the new barbiturate control law, which follows very closely the provisions of the Uniform Barbiturate Act which is in effect in 38 other states, is as follows:

AN ACT

To regulate the handling, sale and distribution of barbiturates.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. For the purpose of this act:

(a) The term "barbiturate" means the salts and derivatives of barbituric acid, also known as malonyl urea, having hypnotic or somnifacient action, and compounds, preparations and mixtures thereof.

(b) The term "delivery" means sale, dispensing, giving away, or supplying in any other manner.

(c) The term "patient" means, as the case may be, (1) the individual for whom a barbiturate is prescribed or to whom a barbiturate is administered, or (2) the owner or the agent of the owner of the animal for which a barbiturate is prescribed or to which a barbiturate is administered.

(d) The term "person" includes individual, corporation, partnership, and association.

(e) The term "practitioner" means a person licensed in this state to prescribe and administer drugs.

(f) The term "pharmacist" means a person duly registered with the state board of pharmacy as a compounder, dispenser and supplier of drugs.

(g) The term "prescription" means a written order, and in cases of emergency, a telephonic order, by a practitioner to a pharmacist for a barbiturate for a particular patient, which specifies the date of its issue, the name and address of such practitioner, the name and address of the patient (and, if such barbiturate is prescribed for an animal, the species of such animal), the name and quantity of the barbiturate prescribed, the direction for use of such drug, and the signature of such practitioner.

(h) The term "manufacturer" means persons other than pharmacists who manufacture barbiturates, and includes persons who prepare such drugs in dosage forms by mixing, compounding, encapsulating, entableting, or other process.

(i) The term "wholesaler" means persons engaged in the business of distributing barbiturates to persons included in any of the classes named in subdivisions (1) to (6) inclusive of section 3 of this act.

(j) The term "warehouseman" means persons who store barbiturates for others and who have no control over the disposition of such barbiturates except for the purpose of such storage.

SECTION 2. It shall be unlawful:

(a) To deliver any barbiturates unless:

(1) Such barbiturate is delivered by a pharmacist, upon an original prescription, and there is affixed to the immediate container in which such drug is delivered a label bearing (A) the name and address of the owner of the establishment from which such drug was delivered; (B) the date on which the prescription for such drug was filled; (C) the number of such prescription as filed in the prescription files of the pharmacist who filled such prescription; (D) the name of the practitioner who prescribed such drug; (E) the name and address of the patient, and if such drug was prescribed for an animal, a statement showing the species of the animal; and (F) the direction for use of the drug as contained in the prescription; or

(2) Such barbiturate is delivered by a practitioner in the course of his practice and the immediate container in which such drug is delivered bears a label on which appears the directions for use of such drug, and the name and address of such practitioner, the name and address of the patient, and, if such drug is prescribed for an animal, a statement showing the species of the animal.

(b) To refill any prescription for a barbiturate unless so designated on the prescription by the practitioner.

(c) To deliver a barbiturate upon prescription unless the pharmacist who filled such prescription files and retains it as required by paragraph (b) of section 4 of this act.

(d) For a practitioner to give a prescription to a pharmacist by telephone unless he gives a written prescription to the pharmacist within 72 hours thereafter.

(e) For any person to possess a barbiturate unless such person obtained such drug on the prescription of a practitioner or in accordance with section 2 (a) 2 of this act or from a person licensed by the laws of any other state or the District of Columbia to prescribe or dispense barbiturates.

(f) To refuse to make available and to accord full opportunity to check any record or file as required by section 5 of this act.

(g) To fail to keep records as required by paragraph (a), (b) or (c) of section 4 of this act.

(h) For any person to use to his own advantage, or to reveal other than to an officer or employee of the state board of pharmacy, or to a court when relevant in a judicial proceeding under this act, any information required under the authority of section 5 of this act, concerning any method or process which as a trade secret is entitled to protection.

(i) For any person to obtain or attempt to obtain a barbiturate by fraud, deceit, misrepresentation or subterfuge; or by the forgery or alteration of a prescription; or by the use of a false name or the giving of a false address.

SECTION 3. The provisions of paragraph (a) and (e) of section 2 of this act shall not be applicable (a) to the delivery of barbiturates to persons included in any of the classes hereinafter named, or to the agents or employees of such persons, for use in the usual course of their

business or practice or in the performance of their official duties, as the case may be; or (b) to the possession of barbiturates by such persons or their agents or employees for such use.

(1) Pharmacists.

(2) Practitioners.

(3) Persons who procure barbiturates (A) for disposition by or under the supervision of pharmacists or practitioners employed by them, or (B) for the purpose of lawful research, teaching, or testing and not for resale.

(4) Hospitals and other institutions which procure barbiturates for lawful administration by practitioners.

(5) Officers or employees of Federal, state or local governments.

(6) Manufacturers and wholesalers.

(7) Carriers and warehousemen.

SECTION 4. (a) Persons (other than carriers) to whom the provisions of section 3 of this act are applicable shall (1) make a complete record of all stocks of barbiturates on hand on the effective date of this act and retain such record for not less than two calendar years immediately following such date and (2) retain each commercial or other record relating to barbiturates maintained by them in the usual course of their business or occupation, for not less than two calendar years immediately following the date of such record.

(b) Pharmacists shall, in addition to complying with the provisions of subsection (a) of this section, retain each prescription for a barbiturate received by them, for not less than two calendar years immediately following the date of the filling or the date of the last refilling of such prescription whichever is the later date.

(c) A practitioner shall, in addition to complying with the provisions of subsection (a) of this section, keep a record of all such barbiturates administered, dispensed or professionally used by him otherwise than by prescription, for not less than two calendar years immediately following the date of the last administering, dispensing or professionally used; such record to give the name and address of the patient, provided, however, that such record need not be kept when the amount administered, dispensed or professionally used in the treatment of any one patient, does not exceed twelve grains in any forty-eight consecutive hours.

SECTION 5. Persons required to keep files or records, relating to barbiturates by section 4 of this act shall, upon the written request of an officer or employee duly designated by the state board of pharmacy, (1) make such files or records available to such officer or employee, at all reasonable hours, for inspection and copying, and (2) accord to such officer or employee full opportunity to check the correctness of such files or records, including opportunity to make inventory of all stocks of barbiturates on hand; and it shall be unlawful for any such person to fail to make such files or records available or to accord such opportunity to check their correctness.

SECTION 6. The state board of pharmacy is hereby authorized to promulgate necessary regulations for the administration and enforcement of this act, in accordance with the provisions of the administrative procedure act.

SECTION 7. Any person violating any provison of this act shall upon conviction be punished by a fine not exceeding five hundred dollars, or by imprisonment for not more than one year, or both such fine and imprisonment.

All fines or forfeited bonds assessed and collected under prosecution or prosecution commenced, shall within thirty days, be paid to the secretary of the state board of pharmacy and by him paid into the state treasury.

SECTION 8. This act may be cited as the uniform barbiturate act.

SECTION 9. If any provision of this act is declared unconstitutional or the applicability thereof to any person or circumstances is held invalid, the constitutionality of the remainder of the act and the applicability thereof to other persons and circumstances shall not be affected thereby.

CHRISTIAN SCIENCE BILL PASSED

On June 16, just as this issue of The Journal was being made up, the Ohio Senate passed House Bill 293, the Christian Science Bill, by a vote of 22 to 8. It had passed the House several months ago. The measure now goes to Governor Lausche. If he signs it (which is anticipated), it will become a law in 90 days. If that happens, Ohio will join the other 47 states, the District of Columbia and the territories in exempting Christian Science practitioners from their Medical Practice Acts.

Civilian Health Officers Needed By Army in Japan

The Department of the Army is urgently in need of public health officers to serve in a civilian capacity with the occupation forces in Japan. These positions which involve supervision of Japanese prefecture (state) health departments in all phases of preventive medicine and medical care programs, offer opportunity for broad experience in public health, according to Army officials.

The salary for these positions is $6,235 per annum plus 10 per cent post differential with quarters provided at no cost to the employee. Individuals selected for appointment must agree to remain a minimum of two years. Dependents may join the employee in approximately six to eight months after his arrival.

Requirements are a degree in medicine plus one year of internship. Those interested should make formal application by submitting Civil Service Commission Standard Form 57 (available at Post Offices) to Civilian Personnel Division, Department of the Army, Washington 25, D. C.

On the Firing Line . . .

Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"I place economy among the first and most important virtues and public debt as the greatest danger to be feared. To preserve our independence, we must not let our rulers load us with perpetual debt. We must make our choice between economy and liberty or perfusion and servitude. If we run into such debts, we must be taxed in our meat and drink, in our necessities and in our comforts, in our labors and in our amusements. If we can prevent the Government from wasting the labors of the people under the pretense of caring for them, they will be happy."—*Thomas Jefferson. (Quoted from a speech by Congressman John L. McClellan before the National Conference of County Medical Society Officers, Atlantic City, June 5, 1949.)*

* * *

"The old people particularly suffer from lack of medical care in Britain today. . . . One of the best informed on the subject told me: 'The best thing that can happen to an elderly person here today is a sudden attack of coronary thrombosis, or a jump off the Waterloo Bridge.'"—*Philip W. Porter, writing from England on British National Health system (The Cleveland Plain Dealer).*

* * *

"The government would like to knock off the purchase tax just as much as you would. You as individuals can perhaps afford to urge that. But as supporters of the government you can't, because we are responsible for finding the money for the existing services. If taxation were thus cut down, then the health service (socialized medicine), or pensions or some other essential item would have to go—or a new tax of equal amount would have to be imposed."—*Remarks of Sir Stafford Cripps to unionists protesting England's purchase tax (sales tax), reported in the Columbus Dispatch.*

* * *

"The Federal government has more publicists on the payroll than all the private public relations firms in the country combined. Every department, agency, bureau, branch and other subdivision, whatever its name, has its staff of publicity workers zealously seeking to protect its interests and put the best possible construction on its activities. . . . They don't mention that in England payroll taxes only finance one-tenth of the (socialized medicine) program, and that the income tax rate is 40 per cent up."—*The Columbus Dispatch*

* * *

"You are being asked to decide whether you want Government-directed medical care, paid for by compulsory contributions and by taxes, or whether you will reject it as a glittering package that will dilute the quality of medical care, stifle the doctors' initiative and nick your purse for unpredictably large amounts. Your decision, in the light of the experiences in Britain and other countries, will profoundly affect your welfare for years to come."—*Steven M. Spencer in the Saturday Evening Post.*

* * *

"The British experiment in socialized medicine is an unfortunate swindle from start to finish, according to a well-known British author, Mr. Cecil Palmer, who has been lecturing in this country.

"This is so, Mr. Palmer says, because it pretends to offer something for next to nothing, and actually gives nothing for something."—*Dr. George S. Benson, president, Harding College, in The Labor Union.*

* * *

"Dr. Willard C. Rappleye, dean of the Faculty of Medicine at Columbia University, recently said that there is little difference between a doctor under socialism and a doctor under fascism. All socialized medical plans, he added, lead toward mediocrity and ultimate destruction of medical education and practice."—*Bucyrus Telegraph Forum.*

* * *

"But to insist that everyone be regimented because a few cannot, or will not, provide for themselves is contrary to the whole principle of freedom.

"And the claim that medical care will be cheaper when the patient, instead of paying the doctor only, pays the doctor plus an army of

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government employees, is too asinine to believe." —*Norwalk Experiment News.*

* * *

"If Congress is going to learn from the experience of others in devising a better public health program in the United States, the place to learn it is from the successful, not the unsuccessful. Germany tried socialized medicine and ruined its medical system. Britain is trying it and British doctors are bogged down with red tape and hordes of patients. The Scandinavian countries have based their health programs on liberty and have set an example of outstanding success that we would do well to follow."—*Indianapolis Star.*

* * *

"A British medical specialist said today that the most serious aspect of the present British national medical insurance plan, from the public's angle, 'is that the apparent material benefits which they get at exhorbitant cost cloak the real loss of true medicine. I sincerely warn the people not to be fogged by a few so-called free medical things to the exclusion of the intangible thing—good medical care,' A. Lawrence Abel, of London, England, said in an interview."—*United Press report on interview during meeting of the American Proctologic Society in Columbus, Ohio.*

* * *

"If we need more doctors, we are not going to attract promising young men into a profession that would make them only glorified government clerks.

"If we need better medical care, we are certainly not going to have it through a system that has corrupted all good standards of medical care wherever it has been tried.

"Compulsory health insurance would be a fraud and a swindle."—*Dr. George S. Benson, president, Harding College, in The Labor Union.*

* * *

"Mr. Herbert Hoover, chairman of the Commission on Organization of the Executive Branch of the Government says:

" 'It is obvious that the burdens that we have to carry are draining the fundamental savings of the people into the Treasury of the United States. We have not socialized property in the United States, but we have come very close to socializing the savings of the American people into the hands of the Government, where Government, if we go on, is likely to be the only source of capital!' "—*From the Toledo Blade.*

* * *

"My uncle is guaranteed a job for life. He is also guaranteed a fixed annual wage. He is guaranteed food and shelter. He is guaranteed an old-age pension. He is guaranteed health and accident treatment. My uncle is in the penitentiary for life.

"P. S.—People who want everything guaranteed in this world have to take the surrender of their freedom to get it."—*St. Louis Pepper Box.*

* * *

"The Administration spokesmen for compulsory health insurance usually dwell on the wage deduction as its main means of support. . . . But the Administration bill itself would tap the Treasury for a lot more. It would permit a direct appropriation equivalent to one per cent of aggregate wages under $4,800 to set up a reserve fund. It would authorize another sum to cover the cost of dental services and home nursing, plus any further sums required to meet expenditures to carry out this title. In other words the funnel is open at the top."—*Steven M. Spencer in the Saturday Evening Post.*

* * *

"Previously a professional man's reputation depended upon ability, industry, personality, opportunity, and luck. Now it will depend not inconsiderably upon the organized plans and dictates of authority However omniscient, omnipotent, and benevolent the central authority may be, it remains the central authority; and so long as its decisions and opinions rule and organize medicine, the profession will have lost its freedom."—*Geoffery Bourne, London, in the British Medical Journal.*

* * *

"The claim of proponents of socialized medicine that patients would still have the choice of doctors is illusory in fact. . . .

"Each doctor will be permitted to have a certain number of patients sign up in advance to be treated by him, and when his quota, fixed by the bureaucrats is filled, he may take no more. When a popular physician's list is quickly filled, patients not included on their favorite doctor's quota will have to be included in some other doctor's list. . . .

"It may be your luck or mine under socialized medicine to draw the quack or drunkard or crook."—*Tom Ireland in the Madison Press.*

* * *

"Again, the President falls into the error of stating that only limited, inadequate health protection is available under the Voluntary Health Insurance Systems. Actually, the voluntary systems are providing better coverage today than any compulsory program yet proposed—at about half the price."—*Dr. Elmer L. Henderson, president-elect, American Medical Association.*

Meiling Named by Defense Secretary . . .

Columbus Physician Appointed by Johnson To Direct Medical Services Of the Armed Forces Under Reorganization Plan Recently Inaugurated

DR. RICHARD L. MEILING of Columbus has been named by Secretary of Defense Louis Johnson to direct the newly established Medical Service Division within the Office of the Secretary of Defense. Dr. Meiling assumes office as deputy director on July 1 and will be elevated to directorship on October 1, Secretary Johnson announced.



R. L. MEILING, M. D.

Establishment of the medical services division is an effort on the part of the Secretary of Defense to unify administration and operation of the medical services of the armed forces.

The Secretary's directive provides that the director of medical services for the National Military Establishment will have responsibility and authority to establish and control general policies, standards and programs for the medical services of the three military departments and related National Military Establishment agencies.

Secretary Johnson also set up an autonomous medical department for the Air Force, which heretofore has been served by personnel from the Army Medical Department. The three military medical departments—Army, Navy and Air Force—will retain their entity under Secretary Johnson's directive, but will operate under supervision by the National Military Establishment Medical Service Division. This direction will be similar to the strategic direction which the Joint Chiefs of Staff give to the unified commanders of the military department.

DUTIES OF DIRECTOR

The duties of the Director of Medical Services are defined as: (1) Establishment and control of general policies, standards and programs for the medical services of the three military departments and appropriate agencies of the National Military Establishment; (2) exercise of general direction, authority and control over administration and utilization of personnel and facilities of the medical services of such departments and agencies through the heads thereof, and (3) such other duties with respect to the medical services of the National Military Establishment as the Secretary of Defense may direct.

In creating the Medical Services Division and providing for the Air Force Medical Department, Secretary Johnson acted on the advice and recommendations of his Medical Advisory Committee. The Joint Chiefs of Staff had previously recommended to the Committee that studies be made of measures intended to produce a unified National Military Establishment medical service.

Dr. Meiling has been very active in organized medicine both locally and nationally, and has contributed unlimited time and effort to place medicine in a position to provide sound logical medical advice at the highest level of national government.

PIONEERED IN AIR EVACUATION

His appointment was made largely in recognition of his work in air evacuation of the wounded during the war. As a medical officer assigned to the Air Forces, Dr. Meiling conceived the idea of evacuating the wounded from the battlefront medical units directly to large overseas base hospitals and hospital centers in the United States by plane. As the only officer who carried the title of Air Evacuation Officer, he set up the world-wide air evacuation service as a result of which nearly 1,400,000 casualties were transported from battlefields. After the cessation of hostilities he was assigned to direct a study of the effects of aerial bombardment on civilian populations.

Dr. Meiling has been a member of the Armed Forces Medical Advisory Committee which is composed of 11 civilian physicians and dentists, the Surgeons General of the Army and Navy and the Air Surgeon. He was one of the consultants to the Eberstadt Committee which had the responsibility of studying the National Security Organization for the Hoover Commission. He also was one of the liaison officers to the Voorhees' Committee which has been called the "medical task force" of the Hoover Commission.

He is a member of the Ohio State Medical Association's Committee on National Emergency Medical Service. Also he is a member and formerly was secretary of the American Medical Association's Council on National Emergency Medical Service. He is an alternate delegate of the Ohio State Medical Association to the Ameri-

can Medical Association and is a delegate of the Columbus Academy of Medicine to the O. S. M. A.

OVERSEAS TOUR

As deputy director of the Medical Service Division, Dr. Meiling is scheduled to travel extensively during July, August and September, visiting strategic areas throughout the world. Dr. Raymond B. Allen, president of the University of Washington, has been named by Secretary Johnson to organize the Division. He will relinquish the directorship to Dr. Meiling on October 1.

Dr. Meiling has been granted a two-year leave of absence from his position on the faculty of Ohio State University College of Medicine, as assistant professor in obstetrics and gynecology. His present plans are to maintain his residence and professional relationships in Columbus.

Medical Advisory Committee Formed by Cincinnati Area Blue Cross

Medical profession participation in the program and policy making of the Cincinnati Area Blue Cross Plan, which comprises 14 counties in south-west Ohio, has taken tangible form with the organization of a Medical Advisory Committee. Dr. J. Stewart Mathews, Cincinnati, was elected chairman; Dr. A. D. Cook, Dayton, vice-chairman, and Dr. Charles E. Hauser, Cincinnati, secretary.

Medical societies in urban counties are now represented with plans under way to add representation from rural counties. Medical society appointments to the committee include Dr. Mathews, Dr. Frank H. Mayfield, and Dr. L. Howard Schriver, Academy of Medicine of Cincinnati; Dr. D. F. Deeter (since deceased), Miami County Medical Society; and Dr. W. D. Beasley, Clark County Medical Society. Dr. David W. Heusinkveld of Cincinnati and Dr. Hauser, members of the Hospital Care Corporation Board of Trustees, serve as ex-officio members of the committee.

Dr. Merrill F. Steele of Cincinnati, chairman, and Dr. Frank C. Sutton, Dayton, vice-chairman, of the Hospital Advisory Council, will meet with the committee to present the hospital administrator's point of view.

The purposes of the Medical Advisory Committee are:

1. To advise and assist Blue Cross in adequately and properly meeting the hospital service needs of its members.

2. To promote a program of education of the medical profession concerning the non-profit prepayment plans, Blue Cross and Blue Shield, for meeting the health needs of the community.

3. To promote and help coordinate a program of public education concerning the necessity of preserving the voluntary methods of meeting the health needs of the community.

Medical Board Waives Full Citizenship Requirement for Two-Year Period

The State Medical Board has adopted a rule which waives for a period of two years a former rule requiring applicants to take the examinations to practice medicine in Ohio to be full citizens of the United States. Only first papers will be required during the two-year period which will become effective in December.

Purpose of this action is to cooperate with the Federal Government in the placement of qualified foreign-born physicians who may be admitted to the United States under the Displaced Persons Act and to help alleviate the shortage of physicians in some areas.

The new ruling, however, will in no way change the Board's prerogative to consider each applicant on the merits of his record and training. Foreign-born applicants who apply for licenses under the new ruling will have to meet all requirements exacted of full citizens in matters of preliminary application, full data about training and evidence of graduaton from an approved medical school, Dr. H. M. Platter, secretary of the Board, explained. Applicants will be required to prove sufficiency in American History and use of the English language.

In regard to applicants from continental Europe, the ruling applies only to such persons as have graduated from medical schools prior to 1943. Graduates of University Schools in Great Britain, who have taken examinations and received licenses to practice in that country, will be eligible to enter examinations.

Action to waive the full citizenship requirement for a two-year period was initiated at the Board meeting on April 19. The final action was taken after a meeting on June 6 opened for public hearings. The ruling will become effective with the December examinations of the Board.

The action by the Ohio Board was taken on recommendation of the Committee on Foreign Medical Credentials, an unofficial body sponsored by the Council on Medical Education and Hospitals of the American Medical Association, and representing in addition the American College Association and various licensing boards and teachers. This committee is proceeding to set up an evaluation unit to act as an aid to the various departments of licensure in considering individual applicants. Similar action is being taken by many other boards of states which formerly required full citizenship of applicants.

Applications are being received for commissions in the newly created Air Force Medical Reserve. Physicians, dentists, nurses, and other medical personnel who served with the Army Air Forces during the war may make application through the Air Adjutant General, U. S. Air Force, in Washington.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

A. M. A. CAMPAIGN AND "CONTRASTS IN METHODS"

In our opinion, Whitaker and Baxter, the firm which is directing the National Educational Campaign for the American Medical Association, is doing an excellent job to date. This opinion is voiced after personal experience on the part of members of the Columbus Office staff with Whitaker and Baxter and its staff in Chicago. But don't take our word for it; read what the *Chicago Journal of Commerce* had to say in an editorial about W. and B. and the A. M. A. campaign, revealing a significant "Contrast in Methods":

"The American Medical Association has done an unusual thing!

"In order to combat misrepresentation of the purposes and methods of its publicity campaign against compulsory federal health insurance, A. M. A. has sent to every member of the 81st Congress a complete, booklet-form breakdown of the association's plan of action.

"Prepared by Whitaker & Baxter, the public relations firm which is directing the A. M. A.'s drive, the booklet carefully blueprints every step to be taken at the county, state and national level.

"If members of Congress take the time to read the plan, A. M. A.'s professional and lay critics will be wasting their time when they charge the organized doctors with sly, unethical propaganda.

"Compare this candid, open position with the statements of Acting Security Administrator J. D. Kingsley when that gentleman testified recently before a Senate committee.

"Mr. Kingsley testified that Mr. Truman's compulsory health insurance program would cost $5,600,000,000.

"If the administration were half as frank as the A. M. A. directors, it would instruct all its witnesses to tell Congress that all cost estimates are at best only informed guesses—and not too well informed at that.

"No similar system anywhere ever has remained for more than a year at most within the original estimate. The cumulative costs of such schemes cannot be estimated.

"Mr. Kingsley also played a variation of the President's theme that existing voluntary health insurance plans 'have proved inadequate.' These plans, said the acting security administrator, cover only some 32,000,000 people 'with limited hospital care only.' His general conclusion was that voluntary health insurance costs too much for most people and cannot pay its way on lower premiums.

"That statement of the case is considerably less than frank. What Mr. Kingsley did not tell Congress, for example, was that the Blue Cross insurance plan was not established until 1934. During 15 years it has had the phenomenal growth of more than 2,000,000 members a year.

"Nor is it true that private plans provide for hospital care only. We now have Blue Shield which insures its member on actual medical service provided by doctors and surgeons. Blue Shield, which has had a somewhat slower acceptance than Blue Cross (largely for the reason that hospital care is usually a much heavier burden of illness than the doctor's bill) nevertheless now has some 10,000,000 members and is growing daily.

"The A. M. A. proposes to sell the American people on the idea that voluntary health insurance is preferable in every way to a compulsory scheme administered by government through state and local officials.

"The federal government, which ought to be encouraging Americans to provide for their own care from their own incomes, instead belittles private insurance plans by telling Congress that such programs are inadequate.

"Actually, in this controversy, the American Medical Association seeks to preserve the traditional American way as opposed to a federal administration trying its best to destroy that way.

"If the nation's press intends to give any prizes for honesty of purpose in this battle of words, let them go to the A. M. A."

BEVIS AND DOAN GIVE THEM THE FACTS

Charges that the College of Medicine, Ohio State University, is not admitting as many freshmen medical students as some persons believe it can and should, were aired recently at a conference called by the Rules Committee of the House of Representatives, Ohio General Assembly.

At the morning-long conference called by the committee, testimony was submitted by President Howard L. Bevis, president of the university, and Dr. Charles A. Doan, dean of the College of Medicine.

Those who sat in on the conference were definitely of the opinion that President Bevis and Dean Doan won the debate—if that is the proper term for the occasion.

The committee was told that the college will be able to admit as many as 150 freshmen medical students in 1951 as a result of expansion of facilities and re-arrangements already made, and will probably increase the number to 200 as soon as the new medical center has been completed—probably in 1952.

Drs. Bevis and Doan rested their case on facts which should be quite obvious to any thinking person, namely, in order to properly train an increased number of students, a school of medicine must have increased facilities and personnel,

and adequate funds must be available to produce such additional facilities and personnel.

Incidentally, it is reported that they also spiked current foolish charges that the American Medical Association or some other agency within the medical profession is trying to keep down medical school enrollment for selfish reasons. Nothing could be farther from the truth. All that accrediting bodies are concerned about is that medical schools are equipped to turn out competent physicians—not just a certain quota of graduates, part of whom would not be able to meet the responsibilities which the good physician of today is called upon to meet.

Here is another perfect example of how rumors can be dissipated and situations clarified by producing the facts and putting them on the line for public inspection.

DEFENSE SECRETARY WANTS FAULTS CORRECTED

In a recent address, Secretary of Defense Louis Johnson referred to the acute shortage of physicians for the armed forces. However, the significant part of his talk was his reference to the reasons for the shortage of medical officers.

Johnson said that he felt the shortage was due to three things: Faulty distribution of available medical officers, failure to get "maximum efficient use of the doctors we had," and lack of unified medical policies among the three armed services. He added that a director of medical services for the national military establishment had been named to take appropriate steps to correct these, and other, faults.

Obviously, Johnson hit the nail on the head, as former medical officers will confirm. His views coincide with the recommendations of the Hoover Commission, also. It is hoped that the Secretary of Defense will be able to correct the faults he referred to and, by so doing, clarify once and for all the question of just how many medical officers are required by the armed forces.

Incidentally, his reference to the new director of medical services is of special interest to Ohio physicians inasmuch as Dr. Richard L. Meiling, Columbus, has been named deputy medical director, and will become the director on October 1.

Those who know of Dr. Meiling's qualifications and his ability in organization techniques are confident that Secretary Johnson made a wise selection. Beneficial results in the efforts being made to straighten out the hodge-podge which has existed too long in the medical activities of the national military establishment can be anticipated.

Dr. Meiling has been highly honored. The military establishment has gained a medical director with outstanding qualifications for the job. Secretary Johnson deserves wholehearted support in his desire to give the armed forces an efficient medical set up.

Regardless of what may be accomplished through reorganization, the armed forces will need some additional medical officers. Therefore, younger physicians who were deferred from military service while finishing their medical education should now fulfill their military responsibility. Several hospitals in Ohio are giving no advance appointments to those who are refusing to recognize this responsibility. It is unfortunate that severe action of this kind has become necessary. Nevertheless, it's a point which should be considered by all hospitals as the need of the armed forces for medical personnel must be met.

TAXES ARE PRETTY HIGH, AREN'T THEY?

Following is the text of a small advertisement published in a Columbus newspaper by the Timken Roller Bearing Company, which tells a vital story in a few words and how necessary it is for Congress to put the brakes on spending sprees:

"Our company taxes are $204,222.00 a week. Our company collects from employes $86,673.00 in withholding tax a week. A total of $290,895.00 for one week. Taxes are pretty high.—The Timken Roller Bearing Company. —Adv."

If you agree with the above, wouldn't it be a good idea for you to drop a note to your Congressman and let him know how you feel? If you think that's someone else's job, you're kidding yourself. Passing the buck to others is out of date.

IN THE END THIS IS EVERYBODY'S BATTLE

Did you see in the 'papers what the British Labor Party, which already has put through a number of socialistic programs, including a socialized medicine plan, intends to do next? You've guessed it: Nationalize more businesses and industries. That's what Messrs. Morrison and Bevan told the Labor Party convention.

Those who believe—or want to believe—that Mr. Truman's socialized medicine proposal is not a piece in a national socialism program, patterned after the British scheme, being hashed up for use in the U. S., are either gullible or just plain dumb, or both. If medicine is swallowed up, industry, all private businesses, farming, and everything else will be next.

Tell your businessmen friends and neighbors to put that in their pipes and smoke it, and that, perhaps, they had better join the medical profession on the firing line, not sit on the

sidelines and say: "How are you doctors coming in your fight against socialized medicine?" That question makes us mad each time we hear it. In the end this is everybody's battle, not just a backyard scrap.

HELP FOR DOCTORS DOING INDUSTRIAL WORK

Physicians doing industrial work would benefit by securing for the price of $1.00 a Manual on Toxic Eye Hazards, prepared by the Joint Committee on Industrial Ophthalmology of the American Academy of Ophthalmology and Otolaryngology and the American Medical Association. It may be obtained from the National Society for the Prevention of Blindness, 1790 Broadway, New York City 19.

The manual contains such valuable material as the following: Standards and Test for Eye Protection Equipment; What Constitutes an Effective Well-Organized Eye Protection Program; Tables of Toxic Chemicals, Their Symptoms and Effects on the Eyes; Emergency and First Aid Procedures in Chemical Eye Injuries.

OHIO MEDICAL CHALKS UP A FINE RECORD

Ohio Medical Indemnity, the Ohio State Medical Association's voluntary prepayment medical care plan, is not only making a name for itself among medical society sponsored medical care plans but also has a record which stacks up exceedingly well against the records of old-line insurance companies engaged in the business of writing health and accident insurance in Ohio.

In a recent issue of the *National Underwriter*, statistics were presented which show that Ohio Medical Indemnity stands seventh in the volume of health and accident coverage written by companies doing business in Ohio. During 1948, Ohio Medical Indemnity collected subscriptions totaling $2,815,733 and paid claims totaling $1,804,520.

Nationally, Ohio Medical Indemnity stands fifth among the medical society sponsored medical care plans, with 531,160 persons covered as of May 31, 1949.

Officials of Ohio Medical Indemnity, its administrative staff, and representatives of the Blue Cross plans which are cooperating with Ohio Medical Indemnity on the solicitation of subscribers and administrative matters are to be congratulated.

Ohio Medical Indemnity's record and the record of the regular insurance companies, offering protection against the costs of medical services, indicate that voluntary insurance can do a real job—in fact can do *the* job—in giving Ohioans the kind of protection they need and should have.

Nevertheless, the surface has only been scratched. More teamwork and more plugging on the part of those who believe this method is the answer to one vital health problem, will be required. Whenever the opportunity arises, give Ohio Medical Indemnity and all *good* voluntary medical care insurance plans a boost. Good protection is available to most wage earners if they will take advantage of the opportunities offered.

COUNTY SOCIETY BULLETINS ARE ON THE INCREASE

Signs continue to indicate increasing activity and alertness among the county medical societies. One of these signs—and a significant one—is the trend toward more and improved bulletins published by local medical units.

Bulletins in printed journal form are now coming to the Headquarters Office monthly from ten societies. Several of the society bulletins are "old timers" and are well known to the medical profession. Some more recent additions to the bulletin family are showing great promise. Most recent of the printed newcomers is the *Butler County Medical Bulletin,* now in its second year of publication. Other societies publish periodic mimeographed bulletins or news letters.

The need for a "house organ," or publication within an organization, is axiomatic. Services of such publications are manifold. Not only do they keep individuals posted, but they act as uniting links to draw members closer together.

Many societies are not in position to support printed publications, but most of them undoubtedly will find that well-prepared mimeographed or multigraphed bulletins will serve useful purposes.

ANOTHER GOOD WAY TO TELL MEDICINE'S STORY

During June, an interesting series of talks was presented before the Marion Rotary Club on the general subject "Your Doctor." The series was arranged for the club by Dr. Carl W. Sawyer to inform members of the club about the medical profession, its activities, its organizations, what it stands for, how physicians are educated, why the profession is opposed to radical legislation, why businessmen should be interested in defeating radical measures, and some of the problems confronting the individual physician in his everyday practice. Four speakers presented the material at four meetings of the organization.

This is an excellent example of good public relations. It's an idea for other County Medical Societies.

Do You Know? . . .

Col. Edward T. Kirkendall, Columbus, has been promoted to the rank of brigadier general in the Medical Reserve Corps. A veteran of World Wars I and II, Gen. Kirkendall was in the ETO for 20 months as commanding officer of the 100th Evacuation Hospital. He is chief of staff at White Cross Hospital.

* * *

Trustees of Western Reserve University have closed the School of Pharmacy, effective June 30, "after 30 years of effort with discouraging results," mainly involving serious financial problems. The school had 19 graduates this year. Efforts will be made by the University to place the remaining 102 students in other schools of pharmacy.

* * *

The Columbus State Hospital in May split with three other institutions the American Psychiatric Association's hospital award, a new prize given for the first time at the organization's convention in Montreal. It was given for the hospitals' achievements in speeding up recoveries by better attendant-patient relations. The other two hospitals were the Boston State Hospital and the Veterans Administration Hospital at Little Rock, Ark.

* * *

Dr. Merrill D. Prugh, Dayton, newly elected Councilor of the Second District of the Ohio State Medical Association, was honored with the annual award of Miami University for "faithful, meritorious service as a loyal alumnus of his Alma Mater."

* * *

Two Ohio physicians received the honorary degree of doctor of laws at the 123rd annual commencement of Western Reserve University, June 15, at Cleveland. Dr. Frank P. Corrigan, former United States Ambassador to Venezuela and advisor on Latin America to the United Nations, was honored as "a competent physician and surgeon and distinguished diplomat." Dr. Howard T. Karsner was cited as "a teacher, author, scientist and leader in the field of pathology." Dr. Karsner is retiring as director of Institute of Pathology at Western Reserve University School of Medicine to become director of the research division of Navy Bureau of Medicine and Surgery in Washington.

* * *

Dr. Evarts A. Graham, St. Louis, who performed the first successful operation for cancer of the lung, was awarded the gold medal of the American College of Chest Physicians, at a dinner at Atlantic City, June 4.

Carl Peachey, for several years in charge of the Toledo Medical-Dental Bureau, is the new executive secretary of the Arizona State Medical Association, with headquarters in Phoenix.

* * *

Full-color lithograph blow-ups of the Fildes painting "The Doctor," captioned "Keep Politics Out Of This Picture," can be obtained, without cost, by writing the State Headquarters Office. Two sizes are available: 19x20 inches and 35x35 3/8 inches.

* * *

The National Bureau of Standards has published a 42-page handbook, "Medical X-Ray Protection up to Two Million Volts," which is purchasable for 15 cents from the Superintendent of Documents, Washington, D. C. The booklet is concerned with standards of safety in installation and operation of high voltage equipment utilized in diagnosis and treatment.

* * *

A total of $270,928,123 was paid to hospitals by Blue Cross plans for the care of members in the United States and Canada during 1948. Payments for members' care in 1948 were $59,-535,238 greater than in 1947. Enrollment in Blue Cross numbers approximately 33,000,000 persons.

* * *

Stanley R. Mauck, executive director of the Columbus Bureau of Medical Economics, is the new executive secretary-editor of the National Association of Medical-Dental Bureaus. Mr. Mauck also is executive secretary of the Columbus Academy of Medicine.

* * *

Four states now have compulsory insurance programs to provide compensation for workers for loss of wages caused by sickness. They are: California, New Jersey, Rhode Island and New York. The feasibility of such a program for Ohio is to be studied by a commission to be created by a bill passed at the present session of the State Legislature.

* * *

Dr. Susan P. Souther, formerly chief of the Division of Child Hygiene, Ohio Department of Health, is now on the staff of the Division of Health Services, U. S. Children's Bureau, Washington, D. C.

* * *

Four years ago Dr. Samuel R. Gerber, Cuyahoga County coroner, and Dr. Ewing H. Crawfis, superintendent of the Cleveland State Hospital, met for the first time in a classroom of the Cleveland Marshall Law School. They received their degrees in law at the School's Commencement in June.

Ohio Golf Tournament . . .

Dr. Donatelli of Toledo Takes Top Honors as Ohio Physician-Golfers Meet at Springfield Country Club for 24th Annual State Tournament

By ROBERT W. ELWELL
Executive Secretary, Academy of Medicine of Toledo

THE 24th Annual Tournament and meeting of the Ohio State Medical Golfers' Association was held on June 16 at the Springfield Country Club. Dr. Joseph Rinehart, chairman of the local committee on arrangements, provided the excellent facilities of this very fine club and golf course to the 93 players of the Association who attended this year's meeting. The large attendance in inclement weather attested to the fact that the O. S. M. G. A. is now a full-fledged organization with a steady influx of new men each year. Thirty-six new fellows were added to the membership roster.

Although the weather was definitely on the damp side some fine scores were recorded by many of the golfing physicians. Dr. Charles Donatelli of Toledo was crowned the Association champion for 1949. This was Dr. Donatelli's second year of competition in the organization and he proved his ability with the sticks by scores of 40-37-35 for 112, four strokes over par. Dr. W. F. Lovebury of Columbus was right behind the winner with scores of 39-36-41 for 116 to place as runner-up.

18-HOLE EVENT

Dr. E. A. Sawan of Akron (playing in his first O. S. M. G. A. tournament) and Dr. J. C. Woodland of Mt. Vernon tied with scores of 77 to be named co-champion of the 18 holers.

The Board of Directors voted to continue the use of the Peoria System of handicapping. It is a method of sampling certain holes (selected by the club pro) from each person's score and computing the players handicap by tables. The players were all placed according to their handicap in one of three flights. The following tabulation of scores is given with net scores shown:

Flight "A" Handicap (0-13)
27 Holes

R. C. Young, Toledo	100
J. C. Olms, Toledo	103
Richard Shoupe, Findlay	106

18 Holes

W. B. Morrison, Columbus	74
A. K. Howell, Springfield	75
W. N. Adkins, Piqua	75

Flight "B" Handicap (14-18)
27 Holes

Joseph Rinehart, Springfield	102
Walter Scheidt, Van Wert	103
Harold Sargis, Lakewood	109

18 Holes

D. A. Weir, Mansfield	75
F. J. Heringhaus, Mansfield	76
H. R. Mitchell, Columbus	81
R. C. Kirk, Orient	81

Flight "C" Handicap (19-30)
27 Holes

Sam Zuker, Toledo	102
W. B. Devine, Zanesville	102
Peter Etzkorn, Lorain	107

18 Holes

W. F. Heine, Circleville	75
O. F. Patterson, Millersburg	76
Warren Fargo, Cleveland	77

Maturity Event was won by Dr. F. M. Green of Columbus with a gross score of 87 while Dr. F. T. Gallagher of Cleveland won the Past-President prize with a gross score of 84. Dr. S. L. Vince of Cleveland won the special event of closest tee shot on the green on number nine hole by a distance of 22 inches.

INTER-COUNTY TITLE

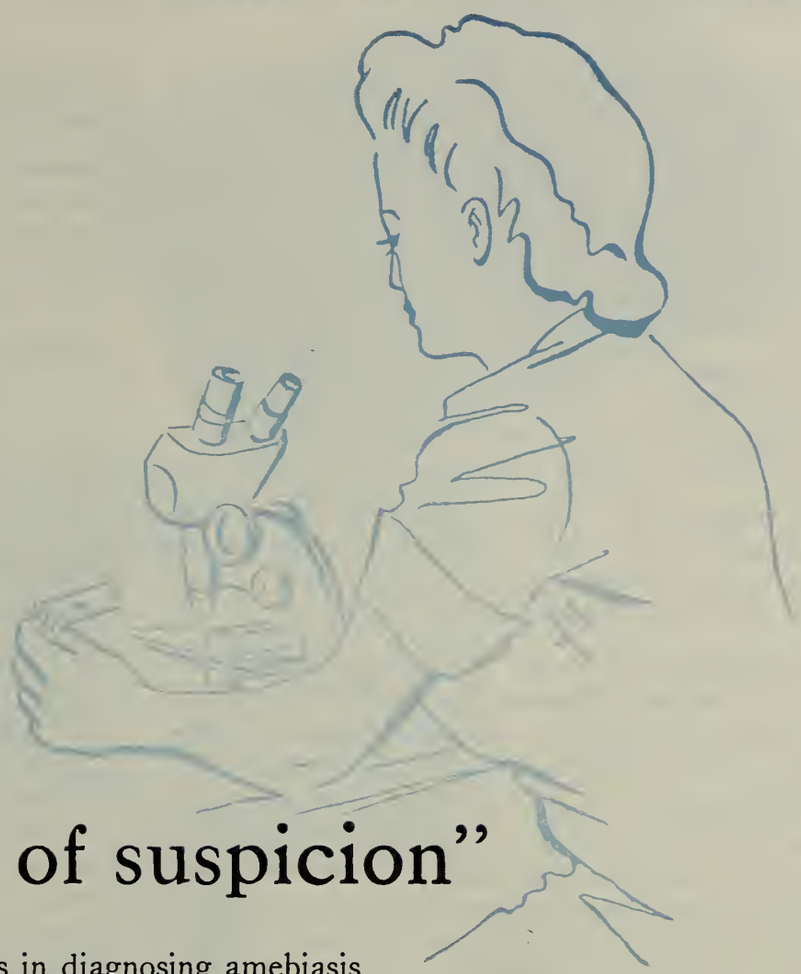
The Ohio State Medical Association presented four individual desk trophies to the winners of the Inter-County events. This year saw 11 teams competing for the attractive trophies. The Columbus team repeated its victory of last year with the winning total of 342 to nose out Zanesville by two strokes and Cleveland by three strokes. The Columbus team had the following scores, Lovebury 75, Keating 96, Green 87, Alspaugh 84.

NEW OFFICERS ELECTED

The annual business meeting of the Association was called to order by the president, Dr. Sam Zuker. Reports were given by the Resolutions Committee and the Nominating Committee. A resolution was passed increasing the initiation fee to $5 for all new members. The treasurer reported that after expenses of this year's tournament were paid there would probably be a surplus slightly in excess of one hundred dollars. The following officers were elected: Dr. George Wilcoxon, Alliance, president; Dr. Floyd Green, Columbus, president-elect; Dr. Joseph Rinehart, Springfield, 1st vice-president; and Bob Elwell, Toledo, secretary-treasurer.

Decision as to where the 1950 Tournament, the 25th anniversary of the organization, would be held was left up to the executive committee.

The day of good golf (for most of the players) and fellowship was concluded by the awarding of prizes to the golf winners and door prizes to each fellow of the Association. Dr. Rinehart and his committee are to be complimented on the splendid list of prizes they assembled and for the cordial reception extended to the membership attending the 1949 meeting.



"A high index of suspicion"

The difficulties and pitfalls in diagnosing amebiasis are stressed frequently in medical literature.

"... despite the absence of a history of dysentery, amebiasis must be considered in the differential diagnosis of many bizarre clinical syndromes.... A high index of suspicion is the keynote of early diagnosis."[1]

In acute or latent forms of amebiasis, Diodoquin may be employed over prolonged periods. This high-iodine-containing amebacide "is well tolerated.... The great advantage of this simple treatment is that in the vast majority, it destroys the cysts of *E. histolytica* and is, therefore, especially valuable in sterilizing 'cyst-carriers.' It can readily be taken by ambulant patients and, therefore, eliminates the necessity of hospitalization."[2]

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

G. D. Searle & Co., Chicago 80, Illinois

1. Warshawsky, H.; Nolan, D. E., and Abramson, W.: Hepatic Complications of Amebiasis, New England J. Med. *235*:678 (Nov. 7) 1946.

2. Manson-Bahr, P.: Some Tropical Diseases in General Practice: "A Post-War Legacy," Glasgow M. J. *27*:123 (May) 1946.

Buckeye News Notes . . .

Chillicothe—Dr. Elsa Klein gave a health talk to girls of the Mt. Logan Tri-Hi-Y Club.

Cincinnati—Dr. John H. Skavlem was elected vice-president of the National Tuberculosis Association.

Cleveland—Dr. Chester R. Jablonoski is the new chief of staff of Marymount Hospital.

Cleveland—Dr. Claude S. Beck was one of two men to receive the Cleveland Public Service Medal presented by the Cleveland Chamber of Commerce at its 100th annual meeting.

Cleveland—Dr. John A. Toomey will direct a series of short courses in poliomyelitis at the City Hospital. The dates—July 18-23; August 8-13, and August 29-September 3.

Cleveland—Dr. David A. Chambers was one of 36 Denison University (Granville) alumni honored at the alumni luncheon climaxing Denison's Family Week celebration.

Cleveland—Dr. Robert K. Spiro, assistant resident in pathology at Cleveland City Hospital, has been awarded the $100 prize for the best thesis on the history of medicine by the Howard Dittrick Museum of Historical Medicine through funds provided by Mead, Johnson & Co. His thesis, "They Shall Not Die in Vain," is a study of the history of autopsy among peoples throughout the world.

Cleveland—Dr. Howard Dittrick is author of an editorial "Anesthesia—A Symphony" in the May-June issue of *Anesthesia and Analgesia.*

Columbus—A full-page color photograph of Dr. Andre Crotti with an accompanying human interest story by Brad Wilson appeared in the May 22 magazine section of the *Columbus Dispatch.*

Columbus—Dr. Oscar L. Coddington has been named president of the Southeast Lions Club.

Findlay—Dr. Senn F. Whisler, Hancock County health commissioner, described the work of his department at a meeting of the Home and Community Council of the Hancock County Farm Bureau.

Fredericktown—Dr. Raymond S. Lord spoke before the local Lions Club on the subject of "The National Health Insurance Bill."

Fremont—Dr. Frank C. Clifford, Toledo, spoke on "Socialized Medicine" before the Fremont Lions Club.

Hillsboro—Dr. W. M. Hoyt addressed the Rotary Club, outlining the work of the Highland County Health Department.

Ironton—Dr. Chester A. Casey addressed the local Rotary Club, describing the future of the Lawrence County General Hospital, which is being remodeled.

Lisbon—Dr. John D. Porterfield, Columbus, director of the Ohio Department of Health, discussed the Columbiana County health program at a public meeting sponsored by the Columbiana County Medical Society.

Mansfield—At a meeting of the Lions Club, Dr. Harry Wain reported on the city-county health program and Dr. W. E. Wygant described operation of the Mansfield blood bank.

Marion—Dr. Warren C. Sawyer spoke on the subject "Civic Problems in Regard to Increased Age Expectancy" before the local Kiwanis Club.

Marion—"The Business Association of Your Doctor, County, State and National," was the topic of a talk before the Rotary Club by Mr. Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association.

McConnellsville—Dr. Deane H. Northrup of Marietta spoke on the subject of "Socialized Medicine" before a meeting of the Rotary Club at which members of the Morgan County Medical Society were guests.

Painesville—Dr. David M. Keating, Cleveland, spoke before a meeting of members of the Registered Nurses Association of Lake and adjacent counties on the subject of "Socialized Medicine."

Perrysburg—Dr. Eugene A. Ockuly of Toledo spoke on "Socialized Medicine" before the local Exchange Club.

Sandusky—Dr. C. E. Swanbeck, Huron, was selected chairman of the Erie County Board of Health.

Shiloh—Dr. Charles O. Butner addressed a gathering of members of the Shelby Federation of Child Conservation Leagues.

Toledo—Dr. W. W. Green was guest speaker at the Annual Meeting of the Detroit Proctology Society in Detroit, Mich.

Troy—Dr. Kenneth F. Lowry was designated an active fellow of the American Association for Surgery of Trauma. He delivered a paper on "Pertinent Factors That Influence Repair in the Treatment of Wounds" before an assembly of the association in Atlantic City.

Vermillion—Dr. C. E. Swanbeck of Huron was chosen chairman of the Erie County Board of Health.

Zanesville—Dr. Robert S. Martin spoke on "A Doctor's Viewpoint on Federal Medical Proposals" at a meeting of the Zanesville Rotary Club.

INTRODUCING...



THE KOROMEX JELLY REFILLABLE UNIT

Physicians acclaim the new Koromex all inclusive contraceptive unit. This fine container is ivory-colored plastic, permanent, dust-proof, attractive for home use and ideal for traveling. It contains two regular size tubes of Koromex Jelly which rest in individual compartments . . . a Koromex Diaphragm stored in the ingeniously constructed cover compartment . . . and a Koromex Measured Dose Plunger Applicator that rests securely on its own rack.

Where pregnancy is contra-indicated, recommend the complete Koromex Jelly Refillable Unit to your discriminating women patients.

For those of your patients who require a slightly less lubricating but equally effective spermicidal preparation, a similar companion package containing two tubes of Koromex Cream instead of Koromex Jelly is also available.

ACTIVE INGREDIENTS: BORIC ACID 2.0% OXYQUINOLIN BENZOATE 0.02% AND PHENYLMERCURIC ACETATE 0.02%, IN SUITABLE JELLY OR CREAM BASES.

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In Memoriam . . .

Reed Oshea Brigham, M. D., Toledo; University of Michigan Medical School, 1921; aged 60; died May 23; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Brigham practiced medicine in Toledo for 28 years. He was a member of the Congregational Church and Sigma Xi fraternity.

Robert Miller Cooke, M. D., Columbus; Ohio Medical University, Columbus, 1907; aged 74; died April 25; former member of the Ohio State Medical Association and the American Medical Association through 1929. Dr. Cooke formerly practiced at Gravel Bank near Marietta.

Orra Fernando Covert, M. D., Moundsville, W. Va.; Rush Medical College, 1901; aged 84; died May 26; member of the West Virginia State Medical Association and a Fellow of the American Medical Association. Dr. Covert was a native of Ohio and conducted part of his practice in this state, especially at Bellaire. He maintained his office and residence at Moundsville from 1904 and retired from practice only about two years ago. He was a veteran of World War I, and held memberships in the Moundsville Country Club, the American Legion, the Rotary Club, the Elks Lodge, the Odd Fellows Lodge and the Presbyterian Church. Surviving are his widow, a son, Dr. L. D. Covert of Bellaire, two brothers and two sisters.

Ernest Crockett, M. D., Ashtabula; University of Michigan Medical School, 1900; aged 75; died May 18; former member of the Ohio State Medical Association and the American Medical Association through 1933; vice-president of the Ashtabula County Medical Society in 1918. Dr. Crockett began practice in Ashtabula in 1900 and continued until his retirement in 1944. He was county coroner from 1916 to 1918. He was a member of the Methodist Church and several branches of the Masonic order. Surviving are his widow, three daughters, a step-son and two sisters.

Clyde Summer Culp, M. D., Salineville; Western Reserve University School of Medicine, 1898; aged 76; died May 28; member of the Ohio State Medical Association and the American Medical Association. Dr. Culp began his practice in Cleveland but for the past 28 years was located in Salineville. He was a member of the Methodist Church and the Masonic Lodge. Surviving are his widow and a step-daughter.

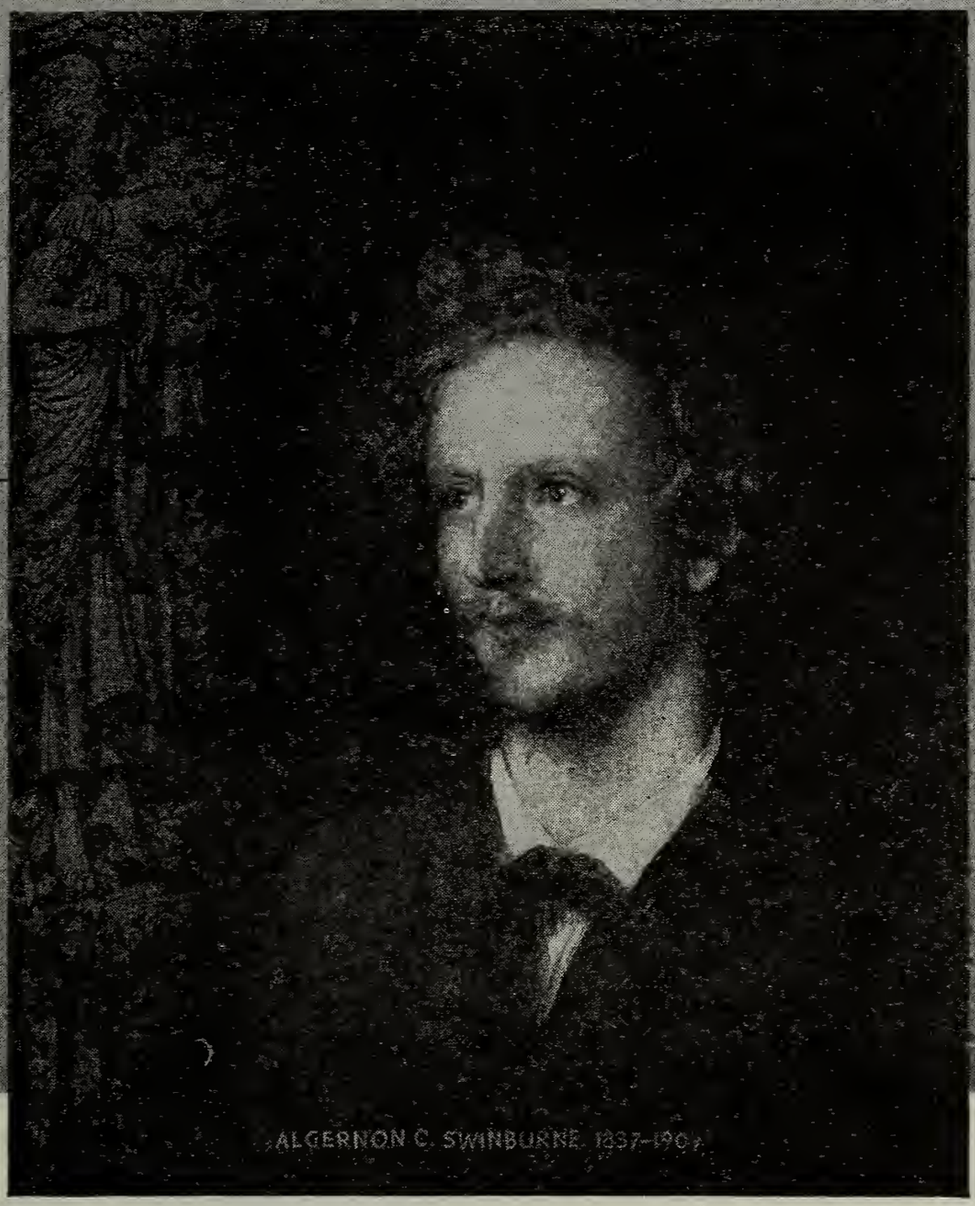
Don Favorite Deeter, M. D., Troy; University of Cincinnati College of Medicine, 1925; aged 52; died May 20; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Miami County Medical Society, 1949. After engaging in extensive residency and fellowship work in Cincinnati and Cleveland, Dr. Deeter took up his professional work in Pleasant Hill in 1931 and moved to Troy in 1937 He was a vestryman of the Episcopal Church and held memberships in the Odd Fellows and Masonic Lodges. A veteran of World War I, he was a member of the American Legion. Surviving are his widow and a daughter and two brothers.

George Benjamin Faulder, M. D., Wapakoneta; University of Michigan Homeopathic Medical School, 1914; aged 57; died May 13; member of the Ohio State Medical Association and a Fellow of the American Medical Association; delegate of the Auglaize County Medical Society in 1937 and 1941. After serving in the Army Medical Corps during World War I, Dr. Faulder began his practice in Wapakoneta in 1919. Besides his professional practice, he was active in fraternal and civic activities. He was a member of the Elks Lodge, several Masonic orders, and the Shawnee Country Club. He served from 1933 to 1941 on the local board of education and was its president for one year. Surviving are his widow, one daughter and a son.

Frank P. Fitzgerald, M. D., Big Plain (Madison County); Medical College of Ohio, Cincinnati, 1884; aged 94; died May 9. Dr. Fitzgerald retired from practice many years ago. He was a member of the Methodist Church and Madison County Farmers' Club and the Grange. Surviving are a daughter, two sons, a brother and a sister.

Alfred Paul Hancuff, M. D., Toledo; Ohio State University College of Medicine, 1917; aged 56; died May 9; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary of the Academy of Medicine of Toledo and Lucas County from 1930 through 1934, and its president in 1942; member of the American College of Surgeons. Dr. Hancuff practiced in Toledo for approximately 30 years. He was a member of the Presbyterian Church, several Masonic orders, Chi Phi and Alpha Kappa Kappa fraternities and the Toledo Club. Surviving are his widow, a son and a daughter.

Harry Haver Hatcher, M. D., Stamford, Conn.; Starling Medical College, Columbus, 1896; aged 74; died May 25; former member of the Ohio State Medical Association and the American Medical Association through 1942; member of the American College of Surgeons. Dr. Hatcher began practice in Dayton in 1897 and continued until his retirement about 10 years ago when he moved to Connecticut. He served for several



★ *Epileptic Men of Genius* ★

The famous English poet, Algernon Charles Swinburne, who began to show signs of epilepsy at the age of 25, is a prominent example that despite epilepsy a man may develop to true greatness.

Comparative studies have shown that in some cases better control of grand mal as well as petit mal seizures can be obtained with Mebaral than with corresponding doses of other antiepileptic drugs. Mebaral produces tranquillity with little or no drowsiness. It is particularly desirable not only in epilepsy but also in the management of anxiety states and other neuroses. The fact that Mebaral is almost tasteless simplifies its administration to children. Average dose for children ½ to 3 grains, adults 3 to 6 grains daily. Tablets ½, 1½ and 3 grains.

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years as Montgomery County coroner. Fraternal activities included membership in several Masonic orders. Surviving are his widow, and a son.

Edward Robert Henning, M. D., Bellefontaine; University of Pennsylvania School of Medicine, 1898; aged 78; died May 31; former member of the Ohio State Medical Association and the American Medical Association through 1929; delegate of the Logan County Medical Society from 1919 through 1923. Dr. Henning moved his practice to Bellefontaine shortly after the turn of the century. In addition to his professional work, he was active in all phases of community life; was a member of the Episcopal Church, several Masonic orders and the Elks Lodge. He was for many years surgeon for the New York Central System in Bellefontaine, was Logan County coroner for eight years and was city police surgeon for a number of years. Surviving are his widow and a daughter.

Elizabeth M. Hocker, M. D., Cincinnati; Laura Memorial Woman's Medical College, Cincinnati, 1897; aged 74; died May 22; former member of the Ohio State Medical Association and the American Medical Association through 1933. Dr. Hocker began practice in Cincinnati after completing her medical education. For many years she was physician for the Catholic Visitation Society which she helped to found. During World War I she served with the Army Medical Corps overseas. She was a member of the Catholic Church, the St. Rita Garden Club, Women's Overseas Club, Mercantile Library Association and Alpha Epsilon Iota sorority. Surviving are a brother and two sisters.

Elmer Grant Horton, M. D., Columbus; Ohio Medical University, Columbus, 1906; aged 81; died May 30; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Pediatrics; member of the American Academy of Pediatrics; emeritus professor in pediatrics at Ohio State University College of Medicine. In addition to his private practice, Dr. Horton devoted much of his time to education. He became professor of hygiene at Ohio State in 1902 and was named emeritus professor in 1939, although he returned to active duty during the war. From 1898 to 1907 he was in charge of Ohio State Board of Health laboratory and from 1907 to 1909 was Columbus health commissioner. He was a member of the Methodist Church, Alpha Mu Pi Omega and Nu Sigma Nu fraternities, the University Faculty Club and the Automobile Club. He held offices in the Lions Club as president of the local club, zone chairman, deputy district governor, governor and international counselor. In college he won many honors as an athlete and continued his interest in sports for many years. He was a past-president of the Professional Men's Bowling Group in Columbus, The O. S. U. medical class of 1933 voted Dr. Horton's portrait to the University. In 1937, the Ohio Public Health Association honored Dr. Horton as one of the founders of the Ohio Tuberculosis Society in 1901. A daughter survives.

Robert A. Howell, M. D., Gallipolis; Medical College of Ohio, Cincinnati, 1895; aged 86; died June 1; former member of the Ohio State Medical Association and the American Medical Association through 1937; member of the legislative committee of Gallia County Medical Society from 1929 through 1934. Dr. Howell practiced medicine at Patriot for many years before moving to Gallipolis in 1926. In addition to his practice of medicine, he was an attorney and was active as an evangelist for the Methodist Church.

Walter Asahel Hoyt, Sr., M. D., Akron; University of Michigan Medical School, 1912; aged 62; died May 31; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Summit County Medical Society in 1927 and a delegate in 1932 and 1937-38; diplomate of the American Board of Orthopaedic Surgery; member of the Clinical Orthopaedic Society, the American Academy of Orthopaedic Surgeons and the American College of Surgeons. Dr. Hoyt practiced in Akron for 33 years. In 1941 he was awarded a certificate of merit at the American Medical Association Annual Meeting for his work in nonsurgical treatment of osteomyelitis. The following year he received the annual gold medal of the American Academy of Orthopaedic Surgeons for the same work. He was active in organizing a local school for handicapped children and in other civic work in behalf of handicapped children. Dr. Hoyt was a member of Sigma Xi and Alpha Omega Alpha fraternities, the Rotary Club, the Akron City Club, the Portage Country Club and the Boy Scout Council. Surviving are his widow, a daughter and a son, Dr. W. A. Hoyt, Jr.

Ernest Kohn, M. D., Grover Hill; Ft. Wayne College of Medicine, 1894; aged 78; died May 10; member of the Ohio State Medical Association and the American Medical Association through 1948; vice-president of the Paulding County Medical Society, 1935 through 1938, delegate in 1918 and chairman of the legislative committee in 1923 and 1925. Dr. Kohn practiced in Indiana and in Van Wert County before moving to Grover Hill in 1911. He was affiliated with the Masonic Lodge and the Knights of Pythias Lodge. Surviving are a son, two brothers and two sisters.

William Henry Price, M. D., Stoney Ridge; Toledo Medical College, 1897; aged 82; died May 6; member of the Ohio State Medical Association and a Fellow of the American Medical Associa-

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tion; vice-president of the Wood County Medical Society in 1930. Dr. Price practiced his profession in northwest Ohio for more than 50 years. For many years he was president of the Farmers Savings Bank in Stoney Ridge. A veteran of the Army Medical Corps during World War I, he was a member of the American Legion. Surviving are his widow, a daughter and two sons, one of whom is Dr. Frederick F. Price of Toledo, two sisters and a brother.

William Landacre Pritchard, M. D., Hilliards; Ohio State University College of Medicine, 1933; aged 43; died May 21; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Pritchard began his practice in Hilliards upon completion of his medical education. He also was active in civic affairs of the community; was a member of the local board of education; was a member of several Masonic orders, Phi Rho Sigma fraternity and the Methodist Church. Surviving are his widow, two sons and his mother.

Charles Frederick Vasey, M. D., Cleveland; Jefferson Medical College of Philadelphia, 1901; aged 73; died May 16. Dr. Vasey moved in 1916 from Lisbon to Cleveland where he continued his practice until his retirement a number of years ago. Surviving are his widow and two sons and a daughter.

Opinions of Attorney General

Following is the syllabus of Opinion No. 529 recently issued by Attorney General Herbert S. Duffy:

1. When a licensing procedure has been established by the Division of Mental Hygiene of the Department of Public Welfare, under Section 1890-20 of the General Code, for institutions caring for the mentally ill, a municipal hospital, which is operated by a municipality and claims to be a public hospital rather than a private one must be licensed in order to care for such mental patients.

2. A non-profit private organization caring for mental patients is required to be licensed.

3. The Division of Mental Hygiene, Department of Public Welfare may not waive the license fee on the ground that it is a charitable organization.

4. Private institutions established for the care of chronic alcoholics may be considered as institutions caring for persons who are mentally ill.

Syllabus of Opinion No. 494 reads: "County commissioners are not authorized to pay veterinary expenses under Sections 5840 et seq. of the General Code, when such expenses have been incurred in the successful treatment of farm animals bitten by a rabid dog. (Opinion of the Attorney General No. 666, for 1927, approved and followed.)"

ROUNDUP ON PREPAID MEDICAL CARE PLANS

Net growth in 1948 for 46 Blue Shield Plans, which were coordinated with 55 Blue Cross Plans, reached a total of 2,699,909 members as compared with a net growth of 2,501,134 members for the coordinated Blue Cross Plans. Blue Shield growth, for the Plans indicated above, was 107.95 per cent of the total credited to Blue Cross.

Total net growth in 1948 for all non-profit medical care plans reporting to Associated Medical Care Plans, totaled 3,130,038, including enrollment figures from 71 Plans, which was 84.9 per cent of the net growth for 90 Blue Cross Plans, totaling 3,686,879 for the same period.

Membership in the 46 Blue Shield Plans stood at 8,606,117 at the end of 1948, which was 35.44 per cent of the 24,281,579 members enrolled by the 55 Blue Cross Plans with which they were coordinated.

Total membership for the 71 Plans reporting to Blue Shield was 10,367,464 at the end of 1948, which was 31.42 per cent of the 32,997,161 enrolled by 90 Blue Cross Plans.

Conclusions drawn from the enrollment studies recently completed indicate a somewhat faster rate of growth for Blue Shield Plans which are coordinated with Blue Cross than for those which are not coordinated.

* * *

Ohio Medical Indemnity, Inc. (the Ohio Doctors' Plan), had contracts covering 531,160 individuals on May 13, an increase of more than 14,400 persons covered during May.

* * *

A scroll, certifying Orval George Stuhr of Daytona Beach, Florida, as the ten millionth Blue Shield member, was presented to Mr. Stuhr, and his family on April 20, 1949, by Dr. L. Howard Schriver, of Cincinnati, president of the Blue Shield Commission, and Dr. Leigh Robinson, president of Blue Shield in Florida.

Mr. Stuhr is an employee of the Borden Company at Daytona Beach, and was enrolled as a member of an employee group by Florida Medical Service Corporation, the Blue Shield Plan serving the people of Florida.

* * *

Having been authorized by the House of Delegates of the Kentucky State Medical Association at its meeting in September, 1948, Kentucky Physicians' Service was incorporated recently and held the first meeting of its Board of Directors in Louisville on April 3, 1949.

High on the list of matters considered was a working agreement between the new medical care

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The use of high protein dietaries has resulted in a gratifying reduction of surgical morbidity and mortality, made possible by systematic presurgical nutritional build-up of the patient. Through this same approach, wound healing and general recovery are greatly promoted.

In nephritis and nephrosis, at one time considered absolute contraindications for animal protein in the dietary, the use of protein in liberal amounts can significantly reduce mortality and decidedly improve the clinical condition.

The benefits derived from high-protein nutrition in pregnancy and lactation are diversified and far-reaching, embracing both mother and offspring. For this reason, a generous extra serving of meat, given daily as a routine measure, has been strongly recommended as a means of improving the health of mother and child.

Meat is rightfully regarded as an outstanding protein source. It is notably rich in protein. The protein of meat is biologically complete, capable of satisfying all protein needs of the body from childhood to old age. And, particularly important in disease, the excellent digestibility of meat gives virtual assurance that its protein and other valuable nutrients become available for utilization.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

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plan and the Blue Cross Plan at Louisville, involving a proposal for joint administration of the affairs of both organizations.

* * *

Fewer than 40 of the 237 cities and towns in New Hampshire remain to be enrolled in community groups in the New Hampshire-Vermont Blue Cross and Blue Shield Plans, R. S. Spaulding, executive director reported. In Vermont 54 community groups have been enrolled as a result of an intensive drive now in progress.

Of the 226,000 participants in Blue Cross, approximately 18 per cent (40,666) are enrolled in community groups in the two states. Among Blue Shield participants, 18.3 per cent (31,068) are enrolled for surgical coverage and 12 per cent (12,144) for medical benefits.

"Present utilization experience warrants continuance of this type of enrollment," Mr. Spaulding claimed, "providing protection to a large number of people unable to enroll through employed groups."

New community groups being organized, or scheduled for early enrollment, will soon complete community group coverage in New Hampshire.

Under a new program, community groups will be expanded on a county-wide basis, replacing the present method of enrolling each city or town separately. Under the county program, every city and town in the area will be open for enrollment at the same time. Local committees will be organized and newspapers and radio used as publicity media.

* * *

Employees of the Ford Motor Company and their families throughout the United States, numbering approximately 300,000, enrolled in December in the Blue Cross-Blue Shield program of non-profit prepaid hospital and surgical care. Arrangements were made by Michigan Hospital Service, Detroit, with the Ford Motor Company and United Automobile Workers C. I. O. Ford's Michigan employees and their families, totaling 215,000, make up the bulk of the Ford employee group, but 33 other Blue Cross-Blue Shield Plans in the various states will administer the plan of hospital-surgical protection for the Ford workers.

* * *

At its meeting in Hollywood, Florida, on April 16, 1949, the Blue Shield Commission accepted three newly organized Plans as members of Associated Medical Care Plans, raising the total membership in A. M. C. P. to 62 Blue Shield Plans, operating in 36 states, the District of Columbia, Hawaii, Puerto Rico, and Canada.

The three new Blue Shield Plans include Kentucky Physicians' Service, Louisville; Northern Illinois Medical Service, Rockford, Ill.; and Rock Island County Medical Service, Moline, Ill.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

BUTLER

Dr. Matthew M. Steiner, Chicago, spoke on the subject of "Problems Related to Endocrinology" at the May 25 meeting of the Butler County Medical Society.

CLINTON

Dr. Carl F. Vilter, Cincinnati, spoke on "Anemia" at the June 7 meeting of the Clinton County Medical Society in Wilmington.

Second District

(COUNCILOR· M. D. PRUGH, M. D., DAYTON)

MONTGOMERY

Results of the election of officers were announced at the June 1 meeting of the Montgomery County Medical Society. Officers are the following, who will assume the offices designated on January 1, 1950: Dr. H. M. James, president-elect; Dr. F. H. Miller, vice-president; Dr. W. A. Reiling, treasurer; and Dr. Paul Troup, secretary; Dr. N. C. Hockwalt, trustee; Dr. R. D. Dooley (reelected) and Dr. T. L. Light, delegates; Dr. J. M. Shaffer, alternate. Dr. H. D. Cassel is the current president-elect and will succeed Dr. E. R. Arn as president on January 1.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D., UPPER SANDUSKY)

HARDIN

"Head Injuries" was the topic of a talk by Dr. Harry LeFever, Ohio State University College of Medicine, Columbus, before the May 19 meeting of the Hardin County Medical Society.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

"Pediatrics in General Practice" was the topic of a talk by Dr. James L. Wilson, Ann Arbor, Mich., at the June 3 meeting of the Academy of Medicine of Toledo and Lucas County.

WOOD

The Wood County Medical Society held its regular dinner meeting at the Everglades Restaurant, Perrysburg, on May 19. In the absence of Dr. Paul Orr, Dr. Frederick F. Price of Stoney Ridge presided.

Dr. F. M. Teeple, commissioner of health for Wood and Sandusky Counties, discussed some proposed changes in the school child immunizing and health examination program. More work in the physicians offices was recommended rather than group work at the schools.

The paper of the evening was given by Dr. Edward Ockuly, of Toledo, on "Acute Urinary Tract Infections: Diagnosis and Treatments." Dr. Ockuly stressed the need for a search for the basic condition that may underlie many similar symptoms and the institution of properly directed therapy. Also the necessity of determining the type of organism present and adapting the anti-infective agent to the condition found. The various remedies—sulfas, streptomycin, mandalamine—were discussed and their relation to renal impairment indicated. Roentgenograms made the paper easy to follow. A question period followed the talk.

This was the last meeting of the Society until September.



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Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

MAHONING

Dr. Edward B. Tuohy, Georgetown University School of Medicine, Washington, D. C., spoke on the role of anesthesiology in modern surgery before the May 17 meeting of the Mahoning County Medical Society in Youngstown.

PORTAGE

"Purpose of the Receiving Hospital and Progress of Mental Treatment" was the topic of a talk by Dr. Eugene Elder of the Youngstown Mental Receiving Hospital before the June 2 meeting of the Portage County Medical Society in Ravenna.

SUMMIT

At the May 3 meeting of the Summit County Medical Society, Dr. A. K. Bochner, Western Reserve University School of Medicine, spoke on the subject of "Frigidity."

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Dr. Harry E. LeFever, Ohio State University College of Medicine, spoke on "Headaches" at the June 16 meeting of the Belmont County Medical Society. Members of the Woman's Auxiliary also were present for the meeting held at the home of Dr. William P. Johnson in Barnesville.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

SCIOTO

Dr. Anson L. Brown of Columbus spoke on "Hematology" at the June 13 meeting of the Hempstead Academy of Medicine in Portsmouth.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

At the June 14 meeting of the Lorain County Medical Society, Dr. F. J. Heringhaus of Mansfield spoke on "Rheumatic Fever."

RICHLAND

"The Rh Problem" was the subject of a talk by Dr. Warren E. Wheeler, Columbus, before the May 19 meeting of the Richland County Medical Society at the Mansfield General Hospital. Following a buffet dinner, Dr. R. R. Crawford, president, conducted a short business session.



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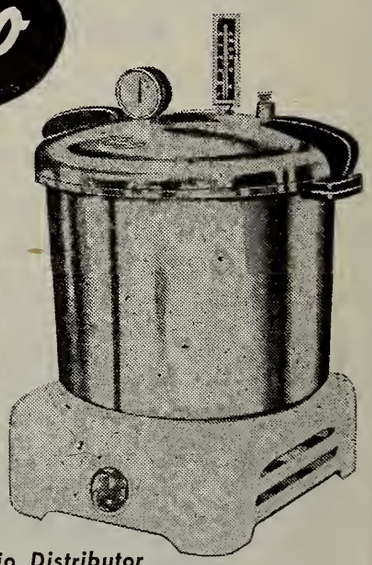
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ASHTABULA

Mrs. Frank Veroni took office on May 16 as president of the Woman's Auxiliary to the Ashtabula County Medical Society. The meeting was held at the home of Mrs. C. T. Risley where a picnic dinner was served to 21 members. Mrs. Paul Longaker was elected to the office of president-elect; Mrs. C. J. Streicher, vice-president; Mrs. E. N. Wright, secretary; and Mrs. W. J. Brown, treasurer. Mrs. A. M. Mills gave a report of the convention sessions held in Columbus.

DELAWARE

A new auxiliary has been organized in Delaware County by Mrs. N. M. Reiff, Tenth District director. The organization meeting was held on May 23. Mrs. Harold Davis of Ashley was elected president; Mrs. A. R. Callander of Delaware, president-elect; Mrs. M. W. Davies of Delaware, secretary; and Mrs. James Parker of Delaware, treasurer. The Delaware County Medical Society entertained the newly organized group with a luncheon.

ERIE

The April meeting of the Woman's Auxiliary to the Erie County Medical Society was something "extra-special"—a dinner given by the wives for their doctor-husbands. The evening's hostesses were Mrs. E. C. Alexander, Mrs. E. J. Meckstroth, Mrs. Dean Sheldon, Mrs. Paul N. Squire and Mrs. C. E. Swanbeck.

The auxiliary president, Mrs. W. T. Fenker, introduced the speakers of the evening—Dr. Ross Knoble, president-elect of the Ohio Academy of General Practice; Dr. Henry W. Lehrer, director of the Lake Erie district of the Academy of General Practice, who is also public relations chairman of the Erie County Medical Society; and Dr. E. J. Meckstroth, new president of the Erie County medical group. Highlighting the evening's program was a play presented by the Harlequins, a little theatre group, entitled "A Doctor in Spite of Himself."

The annual meeting and installation of officers of the Erie County Auxiliary group was held May 9 at the Business Women's Club at Sandusky. The new officers, installed by Mrs. Ross Knoble, include: President, Mrs. C. E. Swanbeck; president-elect, Mrs. E. J. Meckstroth; vice-president, Mrs. P. N. Squire; secretary, Mrs. D. B. Cuthbertson; treasurer, Mrs. H. F. Kesinger. The auxiliary was presented with a gift by Dr. W. T. Fenker—a gavel which the retiring president, Mrs. Fenker, turned over to the new president.

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The business meeting was preceded by a luncheon. The afternoon's entertainment featured Mrs. William F. Burger in a program of songs. She was accompanied by Mrs. John Wild.

LUCAS

The luncheon and annual meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County was held at the Country Club on May 17. There were 120 members present. Election of officers was held. Mrs. F. W. Clement, the new president, was presented with the gavel by the retiring president, Mrs. Green.

Mrs. Maurice Schnitker of the program committee introduced the speaker for the afternoon, Mrs. Paul Alexander, who gave a book review on "Madam Chairman, Members and Guests." Mrs. E. Burns, delegate to the State Auxiliary Convention, gave a report, speaking particularly of the talk made by Mr. Hugh Brenneman.

MONTGOMERY

The May meeting of the Montgomery County Woman's Auxiliary was a tea at which 40 members were in attendance. A book review, "Cheaper by the Dozen," was given. Mrs. Taggart, chairman of the legislative committee, discussed the current aspects of the National Compulsory Health bills.

MORROW

Another new county organized by Mrs. N. M. Reiff is that of the Morrow County doctors' wives who met at Mt. Gilead on May 12. The meeting was in the form of a luncheon and was attended by the doctors and their wives. Mrs. Frank Sweeney was elected president; Mrs. Lowell Murphy, president-elect; Mrs. J. P. Ingmire, treasurer; Mrs. Francis W. Kubbs, secretary.

ROSS

Dr. Robert Young of Columbus, president of the National Association of Physicians and Surgeons, spoke on socialized medicine at a joint dinner meeting held in May of the Ross County Academy of Medicine and its Woman's Auxiliary. Dr. Young, recently returned from England, gave a report of his findings based on the study he had made there of the workings of government-controlled medicine.

Dr. Young noted that the shortage of physicians in the United States had been greatly exaggerated and compared the ratio of one physician to every 2,000 persons in England, with the one physician to every 750 persons in this country.

SCIOTO

Installation of officers and a book review by Mrs. Fred Multer featured the May meeting of the Woman's Auxiliary to the Hempstead Academy of Medicine. The meeting, a luncheon,



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was held at the home of Mrs. A. Louis Berndt, with 33 members present. Mrs. Multer reviewed "The Big Fisherman." At the short business session, reports on the state convention were made by Mrs. Clyde Fitch and Mrs. S. L. Meltzer. A donation was voted for campships for underprivileged girls. A tribute was paid to Mrs. George Obrist, retiring president, who was presented with a gift.

Officers for the new year, installed by Mrs. Milton Levine, are: Mrs. W. A. Ray, president; Mrs. Clyde Everett, president-elect; Mrs. Charles W. Wendelken, vice-president; Mrs. Chester H. Allen, secretary; Mrs. C. L. Ferguson, treasurer; Mrs. J. W. Hutchens and Mrs. J. W. Daehler, advisory board members.

The June meeting of the Scioto County doctors' wives, held at the home of Mrs. Carl Braunlin, honored Mrs. W. W. Scott and Mrs. Fred Jones, two members who are leaving Portsmouth. They were presented with gifts by the auxiliary president, Mrs. W. A. Ray. Entertainment for the afternoon featured a quiz program conducted by Mrs. J. Paul McAfee.

Dr. Stewart Discusses Alleviation Of Army Doctor Shortage

Following is a letter to the Surgeon General of the U. S. Army written by Dr. Dudley M. Stewart of Toledo, a former Medical Corps officer and present officer in the Medical Corps Reserve. Dr. Stewart expresses his personal opinions in suggesting some means of alleviating the present critical shortage of physicians in the armed forces.

Major General Raymond W. Bliss,
Surgeon General of the U. S. Army
Washington, D. C.

My Dear General Bliss:

It is with a knowledge of the shortage of medical officers, and some understanding of your problem in procuring additional medical officers, that I address you. Perhaps the arguments I present may not meet with the approval of top-level brass in the Medical Department, but at least, while this may not be THE solution, it may be an idea which may lead to a solution. A number of mature physicians who have served in the armed forces during the late war have been approached with these same ideas, and they have expressed more than a passing interest in this attempt at a solution of your problem, and a surprising number of these physicians indicated that they would accept career commissions in the Regular Army Medical Department under these considerations. In my opinion, this is a start in the right direction, in the direction of a solution of your problem.

That a draft of young physicians would be distasteful, as well as difficult, is a foregone conclusion and would produce grudging and resentful service; these dissatisfied young medics

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could not be of much value under such circumstances. On the other hand, those physicians who have accepted Federal funds for their medical education have a moral duty to return service for this gratuity under the terms in which they accepted such financing. They owe their country service, and as a taxpayer, I believe they should be the first to be called and no exemptions should be permitted as long as they are fit to practice medicine.

Your problem, as I see it, is to fill the great gap between the young medical officer, who has had training, but who is lacking in experience and judgment, and the older officer, who is burdened with executive and administrative duties. There is need for medical officers who have had training, but who have had years of experience and who have acquired judgment. It is in the procurement of this group of physicians as career medical officers that I am interested. They will fill the gaping void of your department, and will prepare the younger officers by teaching and supervision within the Medical Corps in greater numbers than can be accommodated by the several graduate medical schools. In this way, the Medical Corps can offer the younger physician graduate medical training in the specialties without dependence upon the limited facilities of civilian medical colleges.

These qualified and experienced physicians may be attracted to careers in the Army Medical Corps by offering them inducements in professional opportunity, in pay, in retirement security, and in the exercise of professional initiative at least equal to that offered by the Veterans' Administration for medical and surgical department heads in their hospitals. It must be acknowledged that the Veterans' Administration has more to offer, without the obvious present disadvantages of the Medical Corps, but that their plan has certain drawbacks which have recently made themselves apparent, and which has lost to them many otherwise qualified physicians. If the Medical Department is seriously interested in attracting qualified physicians, now is the time to profit by the errors of the Veterans' Administration, and to offer equal or better opportunities.

There is a large pool of trained, qualified and experienced physicians, many of whom served during World War II, who may be attracted to the military service. They are necessarily between the ages of 35 and 45 years. Should they be offered professional and financial opportunities comparable with civilian practice, and a reasonable retirement security program, I am sure that the Medical Corps would fill its need in this bracket of valuable personnel with little effort. These physicians should be assured of professional duties comparable with their qualifications and experience; given opportunities to teach and to supervise their younger confreres in the service; be relieved of administrative duties; have plans for regular scientific meetings and seminars throughout the service; and to have them supervised and directed by a Director of Professional Services similar to the present medical director of the Veterans' Administration, who is fitted for this position by training and temperament.

It is my opinion that the service of our country should not be made difficult; every effort should be expended to make it attractive. These physicians of whom I have been referring have fifteen to twenty-five years of active profes-

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sional life before them, and the Medical Corps can benefit by their professional work during that time. They may bring with them certain physical disabilities, but these disabilities would not hinder their activities in civilian life, and by a rational attitude toward these disabilities, the worth of the men should be balanced against his physical imperfections. This group of physicians should be essentially hospital personnel, and field physical qualifications should not stand in their way. In the event of future hostilities, you would have an invaluable group of Army trained and seasoned officers who would form a priceless nucleus about whom a rapidly expanding Medical Corps might be integrated into a functioning unit in the least possible time. The trained younger officers would be ready for field installations, and the older group would train and coordinate those fresh from civilian levels. Over-all planning would be simplified, and lost motion would be at a minimum.

There is another group of physicians in the same age bracket whose training and experience qualify them for assignments at staff levels for plans and training activities, for organization and medico-legal work. The same opportunities should be extended to them since they have to offer the fruit of years in such work. One of the greatest difficulties encountered during the past year was a serious lack of knowledge of disability evaluation, and the work of the various boards dealing with reclassification and retirement was greatly hindered, and in many cases, completely fouled up by inadequate presentation, interpretation and judgment. This resulted in dissatisfaction of all parties involved, and much duplication of effort. Therefore, it is my opinion that physicians having knowledge of medico-legal matters and court procedure would be invaluable additions to your department. How much trouble would be prevented if cases could be presented using objective evidence of disability, disability evaluation, and correct interpretation in each instance!

Please be assured that this letter has been inspired by motives both patriotic and practical; that it is with a sincere desire to prevent the unhappy eventuality of a draft of physicians for military service, and an honest attempt to present to you at least some aspects of a solution of your problem of the imperative increase in medical officer personnel, that I address you.

Respectfully,

Dudley M. Stewart, M. D.
(Lt. Col. Medical Corps Reserve.)

Chest Physicians Elect

Dr. Louis Mark of Columbus was named president-elect of the American College of Chest Physicians at the annual meeting in Atlantic City. Dr. Joseph C. Placak of Cleveland assumed office as president of the College.

Dr. Karl P. Klassen, Columbus, was elected president of the Ohio Chapter of the American College of Chest Physicians at the annual meeting of the state organization in Columbus on April 20. Other officers of the state group are: Dr. Lynne E. Baker, Dayton, vice-president, and Dr. E. F. Conlogue, Dayton, secretary-treasurer.

Cook County Graduate School of Medicine

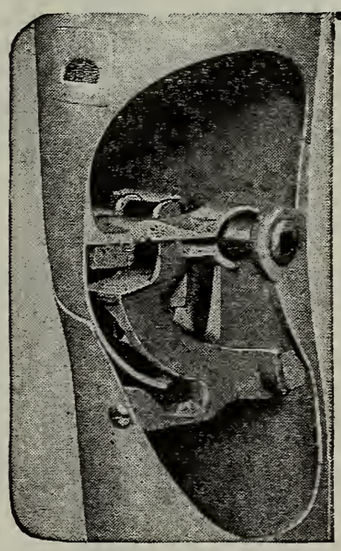
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GYNECOLOGY—Intensive Course, two weeks, starting Sept. 26, Oct. 24. Vaginal Approach to Pelvis Surgery, one week, starting Sept. 19, Nov. 7.
OBSTETRICS—Intensive Course, two weeks, starting Sept. 12, Nov. 7.
MEDICINE—Intensive General Course, two weeks, starting Oct. 3. Gastroenterology, two weeks, starting Oct. 24. Gastroscopy, two weeks, starting July 18, Sept. 26. Electrocardiography & Heart Disease, two weeks, starting July 18. Electrocardiography & Heart Disease, four weeks, starting Sept. 7.
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Health Not To Be Found in Bureauracy Dr. Forman Reminds Dentists

A column in the *Cleveland Plain Dealer* of May 23 was devoted to reporting an address given by Dr. Jonathan Forman, Editor of *The Journal*, before the past-presidents' luncheon of the Cleveland Dental Society.

Following are excerpts from Dr. Forman's talk as reported in the *Plain Dealer*:

SOIL HEALTH

Aside from marshalling the importance of our farmers and their products in the course of our living and our continuing commercial prosperity, Dr. Forman tossed a few eye-openers on the importance of soil health in relation to the nutritive value of our diet.

"No one need tell a group of dentists, or physicians, that nutrition is the key to good health. We are, dentists and physicians alike, devoting our lives to patching up bodies of those who have sinned against the laws of hygiene. We can make repairs, but never restore the body to what it was before the disease struck. Yet when our public-welfare minded bureaucrats attack the health problem, they think in terms of a national program to socialize medicine or dentistry so all can have the benefit of repairmen.

"This idea of a national health service is folly. We can never have enough doctors or dentists to do the repair jobs. In dentistry alone ten times as much work is waiting to be done as there are dentists to do it. To enlarge the dental schools and train ten times as many dentists—to say nothing of doctors—would cost an astronomical sum. In addition, we would be taking out of productive employment, in training dentists alone, some 700,000 of our brightest young men. The course would be national bankruptcy, physical as well as financial.

NOT IN BUREAUCRACY

"The answer to better national health is not in bureaucracy. You cannot legislate health. The answer is in prevention and the first step is diet. If we will give pregnant mothers the best diet, her baby's teeth will set squarely in the little jaw. The jaw will develop with the teeth so there will be no crooked teeth or narrow deformed faces as there are today. Such attention to proper diet would get us off to a good start.

"If we could get our people to go on a diet of whole grain flour, no sugar, rich fruits, leafy vegetables and vitamin and mineral rich proteins supplied by healthy soil and either eaten directly or fed through our animals, our teeth would last as long as their owners even if the owners lived to the 120 years to which we are entitled. By proper attention to diet, we could accomplish 90 per cent of this health betterment in one generation."

Such a dietary program, one that would approximate as good a job as we are doing today in the field of animal and poultry husbandry, would, according to Dr. Forman, do away with any need for a national compulsory health program. Such a result would probably bring weeping and wailing to the bureaucrats—but joy to the rest of us.

BACK TO THE LAND

Aside from his appeal for a better diet, Dr. Forman, in his role as a director of the Friends of the Land, issued a call for improvement in our land use.

"The primary solution to our problem of national prosperity, security and wealth is the conservation of our soil. Today there are no more fertile lands to be developed or occupied. We must work out our salvation on the land we now have. This cannot be legislated by statesmen or politicians, no matter how wise they may be. It must be done by the farmers themselves, the custodians of our land, with what help the rest of us can give."

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Proctologists Celebrate 50th Anniversary in Columbus

Dr. Wendell W. Green of Toledo was reelected secretary of the American Proctologic Society at its 50th annual meeting in Columbus May 31-June 4.

Dr. Louis E. Moon of Omaha, Neb., was advanced to president of the Society. Other officers are: Dr. Hoyt R. Allen of Little Rock, Ark., president-elect; Dr. Herbert T. Hayes, Houston, Tex., vice-president; and Dr. Rufus C. Alley of Lexington, Ky., treasurer.

Research awards totaling $250,000 for studies in heart and circulatory diseases were announced by the American Heart Association.

Dr. Azel Ames, Jr., Hamilton, was elected president of the Ohio Tuberculosis and Health Association at the annual meeting in Columbus.

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FOR RENT:: Doctor's office; well equipped. Mrs. John B. Kistler, R. F. D. 3, Newcomerstown; Telephone 3126.

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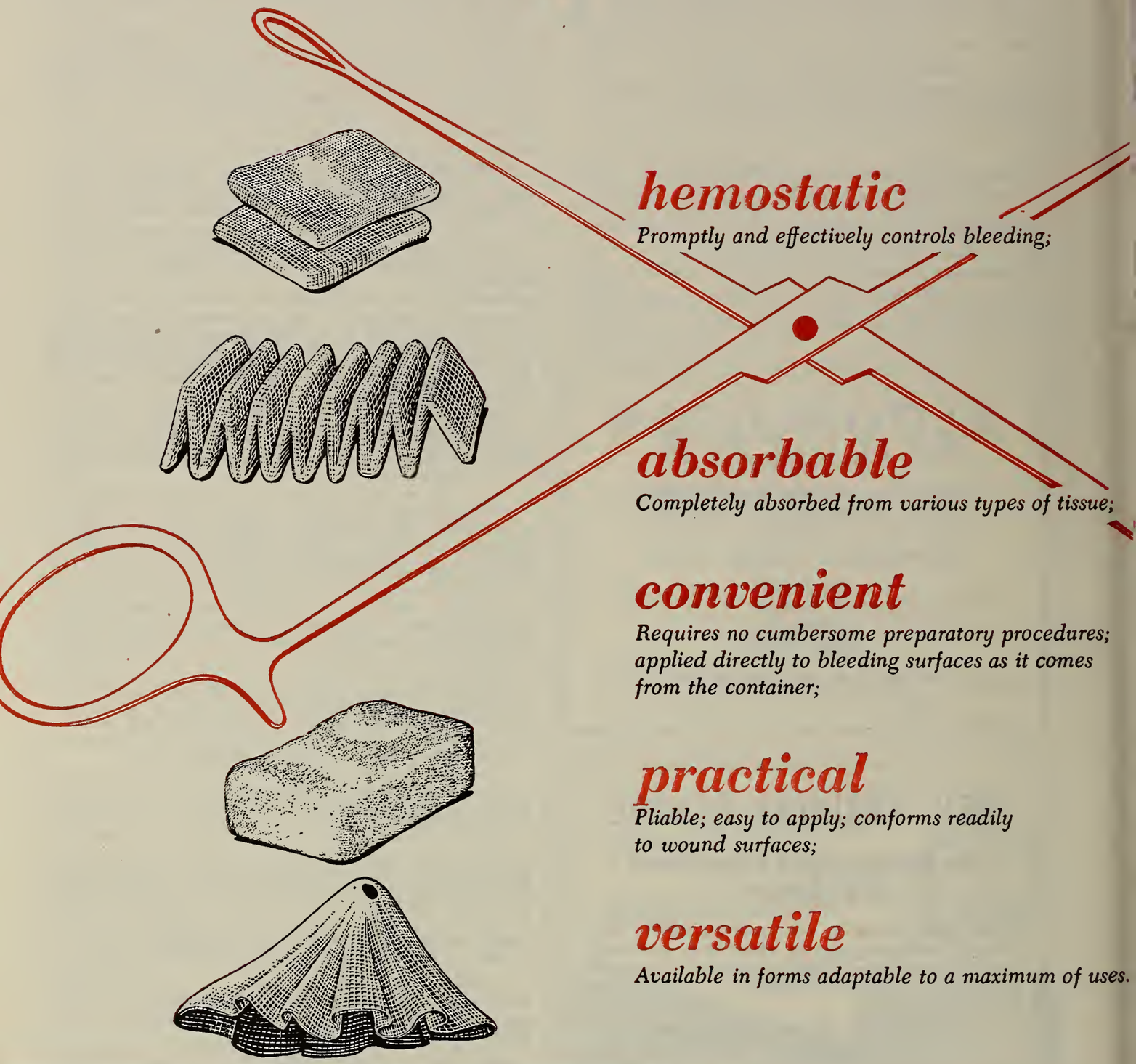
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The Physician's Bookshelf

By Jonathan Forman, M.D.

Soil, Food, and Health

A GOOD many years ago when the Committee on the Cost of Medical Care focused our attention on the problem of sickness, I began looking around for an answer. Quite aware that this was not the function of any government of which I wanted any part, I felt certain that the answer must be in prevention of sickness rather than in the search for more and better care of more sickness.

In my researches into the medical history of Franklin County, I had been aware of the local history of typhoid fever—how typhoid fever supported two medical colleges with large classes and more physicians per capita than we have now with all our specialists and urban concentration of physicians. When a young bacteriologist (the late Elmer G. Horton) was brought in to open a laboratory for the State Board of Health while he got a medical education, Mr. Horton began an agitation for a pure water supply. This invoked great controversy. If the people of Columbus had been thinking along modern lines or if we had had the horde of trained welfare workers that we have now, they would have hired about 400 physicians and 2,000 nurses at the taxpayers' expense and furnished our city with adequate medical care for typhoid fever and allied diseases. But our universities were just beginning to establish their schools of Social Administration; our Federal Government had not begun to rob those who work and produce to give to those who cannot or will not produce; and the leveling of the income tax, so highly recommended by Karl Marx as a tool for the destruction of Capitalism, had not yet begun to pile up money for bureaucratic "do-gooders" to dissipate. Therefore, the citizens of Columbus did a very backward thing—they bought themselves a pure water supply. Not a case of typhoid fever has developed in Columbus since that day. We have had adequate care for typhoid fever without expense to the taxpayer because we have prevented typhoid fever.

I soon saw that public health was purchasable. In so far as the health of the citizens of a community was influenced by communicable and infectious diseases, by the failure of quarantine, the lack of sanitary facilities, including a pure water supply, the refusal to submit to mass immunization and X-ray survey program, the problem is a public responsibility. Personal health, on the other hand, is and always will be a personal responsibility and its advancement a challenge to our educators. Those who have been trained to teach will have to take up the burden of making each of our citizens assume his responsibility in the matter of his own health.

As I and others began to look into the cause of the great increase in life expectancy in our times, we found little for which the medical profession could claim credit. The greatest single contribution had been made by the plumber who conceived the idea of putting the toilet in a warm room in the house and connecting it with a sewer. It was he who created the demand for sanitary engineers and they in turn, working with the bacteriologists, brought us germ-free drinking water. The next great step was the production of artificial ice made from distilled water, to be followed by the mechanical refrigerator and now, the deep freeze. Refrigeration and pasteurization gave us a reasonably clean milk supply. This did away with the summer complaints of our infants and babies.

I came to realize my proper place in the social order. I saw what many do not seem to realize as yet, that we of the Medical Profession, as professional men, have nothing to do with health. We have dedicated our lives to the care of the sick. Never in all of our training was the ecology of man given any consideration. None of our teachers gave the slightest consideration to the biological "norm" in eating, sleeping, and exercising, or the use of stimulants or sedatives; the deliberate gearing of our working load to the strength of our minds and bodies.

About this time (1940), great horror was expressed in many quarters that no courses in nutrition were given in medical schools. So now we do have courses in feeding the sick, but no courses that would induce a medical student to begin to eat within the framework of the biological "norm" for man.

Some attention must be given to this as a possible prevention of the great loss that occurs now in working years, as so many of us physicians die before our time from the so-called degenerative diseases brought on by the misuse and malnourishment of our bodies.

Realizing then (1938) that good health could only come through good nutrition, I saw that none of the plans to institute government-supported medical care for the sick could possibly do more than take better care of sick-

ness, while our population increased and so would the amount of sickness and its cost to the taxpayers. The most that could be accomplished would be to postpone death for a couple years for a couple hundred thousands of our people. None of these would be restored to robust health.

It was logical then that I should respond at once to a challenge issued by O. E. Fink at a meeting of The Columbus Town Meeting of the Air where I was debating methods of medical care with Dr. Kingsbury Roberts of the Cooperative Association. From that day to this I have devoted most of my spare time to correlating all available information on soil-health relationships, and to telling the American people by means of lectures, panel discussions, letters, and frequent radio interviews that there are problems about medical care but, in spite of all of these, we Americans have the best medical care in the world. I have, therefore, urged them to forget compulsory government medicine which may bankrupt the Nation and have asked them to join me in restoring the fertility of American farm land which will bring us all not only prosperity but also health.

To assemble the available information, I conceived the idea of an annual conference where an expert on each step could bring us up to date. Therefore, each year at The Annual Conference on Conservation, Nutrition, and Health, we have brought together authorities on some phase of water, soil conservation, inorganic macro- and micro-nutrients and organic matter in the soil, plant health and disease, animal nutrition in health and disease (both domestic and wildlife), human nutrition, and nutritional deficiencies in relation to reproduction, inheritance and behavior.

To these Conferences each June have come many of the country's top-flight authorities in medicine, dentistry, plant and animal ecology, soil and water conservation, rural economics, philosophy, education, and religion, and plain folks anxious to learn to live within the biological norm for them in their surroundings. Together, we have tried to fit the findings of science together as we have sought to build the pattern of man's relationship to his environment.

On the campus of Ohio University under the shade of the McGuffy elms, planted by the Reverend Doctor William H. McGuffy, himself an early president of the University and author of the famed McGuffy Readers, we confreres have talked of such things as soil losses and humus, nutritional effects of health plants upon teeth and blood vessels, the growth of children and the longevity of their elders.

So, last year when the book publisher, D. A. Garrity, a regular attendant at these Conferences, asked me to write an introduction to an American edition of L. J. Picton's book, which in its british appearance was called **Some Thoughts on Feeding**, I was delighted to attempt to correlate the thinking of the "advanced guard" of English and American physicians who are preaching creative medicine as a better solution for the social problem of sickness. My introduction became an essay on creative medicine along the lines of the above discussion.

Dr. L. J. Picton is chairman of the panel of British physicians who published the now famous **Medical Testament**, a statement of the fact that in spite of their best efforts as medical practitioners, the health of their fellows continued to regress through increasing bad nutrition. After **Medical Testament** appeared, Dr. Picton thought he would like the public to hear the additional points which he personally thought were responsible for the failure of the present-day culture to give the people robust health. (\$4.00. **Nutrition and the Soil**, by L. J. Picton, M. D., with an Introductory Essay on Creative Medicine, *Devin-Adair Company, 23 West 26th Street, New York 10, New York).*

Following our Annual Conference on Conservation, Nutrition, and Health, I assembled the 15 important papers and threaded them into a discussion of what we have learned about soil-health relationship in the previous Conferences. We have written a short essay as a background to each of the sections and a statement of our concept of disease—an ecologic concept involving social pathology as of equal importance to bacteria as a cause of death. (**Soil, Food and Health**, edited by Jonathan Forman, B. A., M. D., F. A. C. A., and O. E. Fink, M. A., \$4.50. *Friends of the Land, 1368 N. High St., Columbus 1, Ohio.)*

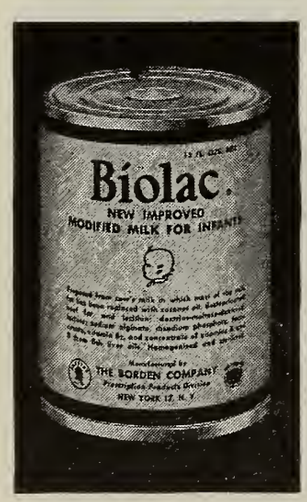
Sexual Disorders in the Male, by Kenneth Walker and Eric B. Strauss (\$3.50. Third Revised Edition. *Williams & Wilkins Company, Baltimore, Maryland)*, has placed more emphasis on the psychic as opposed to the somatic side of sexual disorders especially as it concerns treatment. The one big lesson for us physicians in this work is that "marriage in itself is never the cure for anything, least of all for psychosexual anomalies."

Oral and Dental Diagnosis, With Suggestions for Treatment, by Kurt H. Thoma (\$9.50. Revised Third Edition. *W. B. Saunders Company, Philadelphia)*, has been through a complete job of revision with specific addition on treatment. Not only has the text been completely rewritten, but 110 new illustrations have been added. We have now what the author set out to make, viz., a presentation of each disease entity as a clinically complete, diagnostic description with the history-taking, physical examination and laboratory tests that are necessary.

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Vol. 45 August, 1949 No. 8

JONATHAN FORMAN, M. D., *Editor*

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Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

The Management of Functional Derangements of the Gastro-intestinal Tract

HAROLD C. KLEIN, M. D.

FUNCTIONAL disorders of the human mechanism are as old as man himself. They are the basis of a large number of patient visits to the doctor. In gastro-enterologic practice, functional disorders comprise well over half of the total number of patients seen. Despite the enormity of the problem and the welter of literature touching various phases of it, the management of these cases is relatively obscure. The matter has been approached from so many different angles that the reader, searching for a simple pattern, is soon lost in a maze of vague terms and differences of opinion and is unable to formulate a completely satisfactory system of treatment.

Medical science has made vast strides in the management of organic disease with comparatively little advance in the handling of functional ailments. As a result, the practitioner has been placed in the position of hoping to find simple organic disease in his patients because therein lies his greatest opportunity of accomplishing real relief or cure. It is after he prods, pokes, examines and exhausts laboratory and X-ray facilities, and finds nothing organically wrong, that he is hard pressed for a suitable plan of therapeusis.

Some of our internists believe that the management of functional illness is out of their domain. They feel that their obligation to the patient is satisfied if a complete survey fails to reveal organic disease. However, the pangs arising from a functional disorder can be more distressing and more debilitating than those of real disease. These people cannot be left to shift for themselves without medical guidance. It is as much our duty to return them to a high plane of efficiency and well-being as it is to treat any other disease to which the human body falls heir.

In the successful management of any disease entity, it is essential that the physician establish in his mind a clear concept of the mechanics of the illness with which he is dealing. This is particularly true in functional disorders where it is necessary that a satisfactory explanation of the condition be transmitted to the patient and his assistance enlisted. Despite the recent reawakening of interest in psychosomatics, the exact nature of disorders of function are still not clearly defined. It is this very lack of clarity that has been the cause of our poor results in treatment. These failures can be prevented for the most part if a definite pattern of management is outlined and built around a concise understanding of the disease. The basic essentials for such an understanding should include a good concept of the mechanism of the production of symptoms, a simplified classification, a method for

The Author

● Dr. Klein, Cleveland, Ohio, is a graduate of Georgetown University School of Medicine, Washington, D. C., 1940; member, American Gastroscopic Society; and assistant clinician in medicine, out-patient dispensary, Mount Sinai Hospital, Cleveland.

Submitted November 10, 1948.

making a positive diagnosis, and a definite and uniform plan of treatment.

SYMPTOMS

It is beyond the scope of this discussion to go into the complex theories about the production of symptoms. The organ expression of fears, anxiety, hate, rage and other emotions forms a basis for the work of the psychosomatists. Much of the thinking on the physiology of these processes that implicate the autonomic system, the vagus, emotional imbalance, etc., are not as yet sufficiently concrete to permit a good basic concept. As a background for treatment, the physician should do well to accept the simple idea that irregularities of function such as spasm, hypermotility, hypersecretion, etc., may appear in an organically sound gastro-intestinal tract as a result of excessive emotional play. The disturbing emotional element may be obvious and acute such as financial trouble, impending trials, or a death in the family. The diarrheas and dyspepsias arising thereon are acute, short lived, and rarely troublesome. More commonly, it is the subconscious smoldering conflicts, fears and anxieties that do their work slowly and progressively until overt trouble is established. It is the chronic, persistent case that presents difficult problems in management and is the subject of this discussion.

With the appearance and persistence of symptoms, fear arises in the patient's mind that he is suffering from an organic disease—most usually cancer. Whereas the original symptoms may have been mild and non-debilitating, this fear of organic disease adds another weight of emotional tension to an overloaded system, and exacerbates the illness. It often becomes the major and dominant factor in the case and is the agent that sends these patients hurrying to the doctor. Any attempt at successful management must bear the element of this fear clearly in mind.

CLASSIFICATION

Although it is generally accepted that all functional aberrations stem from the same fundamental source, no uniform classification of the gastro-intestinal manifestations is utilized. A good deal of confusion arises from the separation and description of the various components of functional disorders as separate and distinct entities. In an effort at clarifying this situation, we would suggest that all of the gastro-enterological components be carried under the general heading of "Functional Derangement of the Gastro-intestinal Tract." The specificity of the disorder may then be expressed in terms of "gastric preponderance," "colonic preponderance," or whichever portion of the system has been selected as the medium of symptom expression. By so doing, we may discard such confusing names as "irritable colon," "gastric neurosis," "mucus colitis," "spastic constipation," "biliary dyskinesia," etc., and the implication that these are all different conditions no longer shades the concept. Such a classification is simple and unified. It emphasizes the fundamental difficulty and invites a direct approach to the basic problem.

DIAGNOSIS

A diagnosis is an obvious prerequisite to treatment. Making a positive diagnosis of a functional derangement is not a simple matter. Although much has been written about psychesoma relationships, about signs and symptoms that should arouse a suspicion of emotional weaknesses, and about suggestive X-rays, there are no positive signs or absolute symptoms that enable us to reach such a final impression. Undoubtedly, a correct diagnosis of functional disease may frequently be made in the consultation room from the history alone. However, the symptoms of severe gastro-intestinal disease may be so vague that a thorough study is always indicated. Constipation, aching in the lower abdomen, and stools covered with mucus may suggest a functional spasm of the sigmoid but may also be found with diverticulitis or cancer of the colon. Flatulence, dyspepsia, or vomiting, however mild, may be associated with gastric malignancy or biliary tract disease. Any series of symptoms commonly thought to indicate functional disorders only do so by implication. They may imply the presence of disordered function, but are by no means certain evidence of its existence. Obvious emotional instability may be a clue but nervous, high-strung individuals are just as susceptible to organic disease as the complacent ones. It is therefore necessary to rule out all possible organic lesions first, using all the methods and tests at our disposal. The positive functional diagnosis is therefore made only on the basis of negative tests and examinations.

Following this course will of necessity markedly increase the financial burden on the patient and it may be argued that with all symptoms pointing toward a functional diagnosis, such patients should be spared the expense of X-ray and laboratory tests. It has been our experience, however, that regardless of the reputation or esteem of the physician, patients of this type are not afforded the mental relief of a negative report without thorough study. They know about the availability of X-ray facilities and laboratory tests. They feel that there is some organic basis for their illness and must be assured that all elements in their structure have been carefully examined before they can accept the doctor's word that the reason for their distress is a disorder of mechanics alone. It is difficult for the individual to believe that excruciating pain may be caused by simple spasm or that an organically

sound stomach could permit of repeated vomiting. He cannot and will not accept this explanation of his difficulties unless the physician has made every effort in a search for the cause. This makes a thorough study mandatory since the patient must have complete confidence in the diagnosis for the management to be successful. Otherwise, he will continue to shop for more and different medical or quasi-medical opinions until the bill exceeds what an original thorough examination would have cost.

Complete examination is also indicated so that the doctor too may have doubt removed from his mind and may then be sure in his approach to the problem. He, too, must overcome the fear that something was missed in the course of the study of the patient. We are constantly reminded in the reports in the literature and in clinical discussions about the rare and unusual case. Our minds are plagued by reports of patients treated as functional illness for months or years in good clinics until operation or autopsy revealed a lymphoma, an endocrine dysfunction, or some other obscure lesion. This creates a stumbling block in our thinking processes because the wise physician knows that he can err despite all our advanced methods and is cautious about making a definite statement to the patient. Positivity, however, is essential for success. The bizarre and unusual should be relegated to their level of importance. It must be borne in mind that they are the rare exception, and, at least for the patient's benefit, the doctor must come to peace with himself and make the positive diagnosis of functional derangement on the basis of negative complete studies.

It is therefore a prime essential, both for making the diagnosis and for the successful management of these disorders, that all the symptoms be explored and all indicated tests be performed. If this is not done, the existence of doubt at one or both ends of the patient-doctor rapport structure dooms to failure any effort at affording relief.

Now that the diagnosis is thoroughly established, the physician is faced with the problem of managing the patient who has "nothing wrong" but is sick.

MANAGEMENT

The symptomatology and manifestations of functional disease are so protean that it is obviously impossible to propose a simple treatment form that would be equally efficacious for all cases. Perhaps it is the very individuality of symptom assortments that has blocked the presentation of a clear-cut pattern of approach. It is important, however, that a uniform plan be formulated as a guide for the management of all these cases so that therapeutic effectiveness is not lost in haphazard and aimless trials. Once established, such a plan of therapy should act as an outline only, its details to be varied according to the requirements of the individual patient. The basic elements of such a plan are primarily psychotherapy, and secondly, medications. Of paramount importance to the success of the treatment is the manner in which it is applied to the patient.

PSYCHOTHERAPY

Talk of psychotherapy as a measure in management is generally anathema to the minds of many physicians. Schooled in the use of objective methods, they are at sea with the vagaries of pain thresholds, emotional instability, personality types and constitutional inadequates. These terms carry very little meaning or value in regard to the patient in the office with his particular complaints. Our search is focused on the cause of the difficulty, and the personality of the patient is usually lost in the shuffle. The medical man has been taught that for heart failure he gives so many grains of digitalis a day or for an infection, so many units of penicillin per injection, but for functional disease, he is told to have understanding and sympathy and the only concrete thing at his command is phenobarbital grains ¼ three times a day. With the majority of our patients falling in the latter group, surely we can't believe that the little white phenobarbital pill will cure all of them. The problem is far too great and theorizing is not enough. We cannot throw all these people on the doorstep of the phychiatrist. They are problems for us, the medical men, to whom they come. It is true that many of their environmental problems are insoluble in a medical office. It is not in our domain to dissolve incompatible matings, rebuild financial insecurity, or settle family squabbles, but we can explain how the tension that these problems create can cause the symptoms. It is not the pain itself that brings the patient into the doctor's office but more the fear of what that pain signifies. The pain is bearable but the fear that it may be caused by a cancer or a bad heart is suffocating in its intensity. If we can allay this fear, the pain will subside into the foggy realm of the inconsequential. Such reassurance is true psychotherapy and is the simplest and most effective form of treatment we have to offer.

The first step, therefore, in leading the patient back to health is the presentation of the negative findings and the assurance that all his organs and structures are in no manner abnormal or diseased. The importance of this procedure is emphasized over and over again in our medical teachings and great care must be taken to see that it is done correctly. No information should be given during the course of the investigation. The treatment starts after all examinations and tests have been completed and the patient is dressed and back in the consultation room.

The "there's nothing wrong with you" atti-

tude is still an offending approach. Actually it is a summary of what there is to say when the work-up is finished, but it is definitely an improper method. It is best to list the various organ systems, giving a negative report on each. This again gives the patient the satisfaction of knowing that he has been thoroughly studied and removes the shades of doubt and fear that are so much a part of his make-up. In the course of this report to the patient, it is inadvisable to mention any of the medically interesting but noncontributory findings. Azygos lobes, Phrygian caps, minor cardiogram changes, etc., are straws for the grasp of the anxious patient looking for some objective cause for his ailment. Any minor aberrations such as a mild hypertension should be cushioned with the explanation that it is within the range of expectation for an individual of that age and type and will do no harm.

After being told that he is perfectly normal physically, the next step must of course be an explanation to the patient as to just what is the nature of his illness. He must be informed to his satisfaction why he perceives pains and discomforts. The explanation can and should be simple and clear. In terms of simple mechanics or others to suit his background, he can be made to understand how excessive emotional pressures may overflow and seek escape through nerve channels running down to the gastrointestinal tract, and how these stimuli may cause excessive or abnormal activity of parts of the stomach or intestines and thereby produce the symptoms. Diagrams may help to show how sigmoid overactivity can create constipation, mucus and gas, or, how overstimulation of the stomach and pylorus can cause vomiting. It must be emphasized that the organ itself is normal but is merely functioning abnormally in response to excessive stimulation. A part of the explanation is the assurance that the physician knows that it is not an imaginary illness and that the pain and discomfort are real. These people deeply resent being told that "it's all in the head." The general discourse on functional illness should then become personalized and the mechanics of the individual's own symptoms should be reviewed. He should be given a good idea as to how each developed—the reasons for his gas, his cramps, the mucus and the vomiting.

The greatest care must be taken to talk positively and without qualification. Indefiniteness and vagueness at this point can defeat the entire effort. It is a great temptation to inject loopholes in the explanation by using such words as "maybe," "perhaps" and "usually." This may salve the physician but does irreparable damage to the whole scheme of management. It makes the reassurance negative rather than positive and thereby dissipates the strength that is required to quiet the fears of these hypersensitive people.

Such reassurance, positively and emphatically given, accomplishes a first and major step in management. In the simpler forms of functional illness, it may be sufficient in itself to establish enough insight into the problem for the patient to stop the train of symptoms. That is the relatively uncommon case which is caught early before well-meaning friends, helpful pharmacists or inadequate medical care have permitted the symptom complex to become ingrained and before the patient becomes self-convinced that he is harboring real disease. Unfortunately, most cases have been "through the mill" before they are seen. On recommendation from the butcher, the baker, or the neighbor, they have taken all the laxatives, stomachics, tonics or bulk producers known to past or present pharmacopeas. They have become convinced that they have nothing short of some horrible malignant growth and finally seek medical care in desperation. These people may have had their disease for many years. Many have received haphazard medical management and, failing to respond, have been told that theirs is a functional disease that they are fated to carry for life and for which very little can be done. Some of the spastic colon cases have been taking enemata for bowel evacuation for ten years or more. These more stubborn cases require additional help from medication.

The general psychotherapeutic measures are aimed primarily at changing the attitudes of the patient toward the daily incidents of life. We do not subscribe to the belief that functionally disabled individuals are so afflicted because of inherently weak "cloth" in their physical makeup. We would rather believe that theirs is more a problem of poor mental attitudes, a pessimistic outlook and an overdramatization and magnification of daily experiences which create an overplay of the emotions. The excessive emotional pressure so created overstimulate and run down an organically sound mechanism. Attempts should be made at changing these attitudes by giving the patient some insight into relative values. Such instruction will help to some extent but is rarely attended with any degree of prolonged success when practiced within the limited scope of the internist. Such effort should be made to at least apprise the patient of an avenue of escape. The patient himself, given proper direction, must then make his own adjustments and help himself root out the basic difficulty.

Certainly, most of the cases of functional derangement are not in need of specialized psychiatric care. Their general behavior patterns fall well within the accepted normal range. Successfully evening the temper of their quirks and foibles was the forte of the old time general practitioner. The small group, however, whose symp-

toms are rooted in strongly neurotic or frankly psychotic conflicts, should be recognized and referred for good psychiatric management after a thorough study has failed to reveal organic disease in the gastro-intestinal tract.

DRUGS AND DIET

Medicine is secondary to psychotherapy in the management of functional disorders both in importance and in administration. Positive reassurance must come first and is a necessary step before any real help from drugs may be obtained. Sedation and spasmolysis are the accepted goals in the medicinal management of disorders of function in the gastro-intestinal tract. The sedatives and anti-spasmodics available on the market are legion, attesting to the widespread prevalence of these disorders. It is beyond our purpose to discuss the relative merits of these preparations. Actually, the choice of one over the other is a matter of personal usage and experience. We feel that belladonna is still a drug of choice despite commercial ballyhoo to the contrary. It must be remembered that atropine or belladonna must be given to the point of tolerance to be effective and that the tolerance dose may vary with each individual. In colonic disorders, where the stool has become inspissated and fragmented because of stasis and slow passage proximal to a spastic sigmoid, it is helpful to use a bland bulk producer as adjunct treatment.

In prescribing, it is advisable to offer medications in a different form than the patient has ever taken before. Repeat usage of medicines that have failed once are wont to fail again. In taking the history, a full recitation of all previous medications should be elicited so that this error may be avoided. It is interesting to note how often a good response to a simple drug is reported after the patient has been mentally prepared by examination, explanation and reassurance in comparison to the repeated failures of the same drug in the past. In this regard, it may be pertinent to recall the experimental work of Wolf and Wolff who have shown that the action of drugs on the gastro-intestinal tract will vary in relation to the condition of the bowel at the time the drug is applied.

No intimation should be given the patient that the medication is a specific for the disorder or is to be looked upon as a cure. It should be explained that it is to serve merely as a "crutch" to help him along until he is able to manage for himself. We refer to it as the oil to lubricate the machinery and get it running smoothly again.

The value of diet is open to question. It has been our experience that changing the residue content of the diet has relatively little effect on the outcome of the case. The elimination of non bland foods early in the course of treatment may be of some value. On the other hand, ill-advised diet counselling may vitiate the entire effort. Most people overestimate the importance of the things they eat and strict regulations and interdictions may send them away with the belief that they have serious disease despite all assertions to the contrary. Generally, we permit a full diet unless there is definite indication for restrictions.

COMMENT

One final comment should be made. It is quite obvious that following the regime of management here outlined will be time-consuming. Unfortunately, there are no shortcuts. The only substitute for time and patience is failure.

KEEPING UP WITH MEDICINE

• FOR senile pruritus in men use as an adjunct to the treatment, 5 mgm. testosterone propionate subcutaneously every five days.

* * *

• FOR headaches associated with arteriosclerosis, nicotinic acid 50 mgm. twice daily may be tried.

* * *

• THE "undercoat" for fingernails can be the cause of an eczematous contact type of dermatitis of the fingernail bed.

* * *

• IT should be remembered that the cessation of sweating is a highly characteristic premonitory indication of the onset of a heat stroke. During a heat wave, older persons should be carefully observed for this sign.

* * *

• THE objective of geriatric medicine is to add breadth and depth, rather than mere length, to life; and most of the progress so far has been in laying the unspectacular but necessary foundation.

* * *

• IT is easier to vaccinate than to educate.

* * *

• PHYSIOLOGICAL tone is so intimately connected with emotional balance that dynamic psychiatry is an indispensable tool of preventive medicine."

* * *

• SCHNEIDER has localized but not identified an agent in the germ of whole wheat which has increased the resistance of the animal to infection.

* * *

• IN the age group 10 to 14 years of age, accidents outrank diseases of the heart, the single greatest non-accidental cause of death, 5 to 1.—J. F.

Sweets and Tooth Decay

PAUL C. KITCHIN, D. D. S.

TO UNDERSTAND the relation of sweets to tooth decay, it is necessary to know what happens to a tooth when it decays and what causes the process to start.

Tooth decay occurs in two principal steps. The first is a localized removal of calcium salts, or a decalcification process, and the second is a bacterial invasion and destruction of that tooth substance which is no longer protected by being calcified. In preventing the process, our main concern lies with the first, or decalcification stage. How is acid formed, protected from dilution and destruction by the saliva, and retained in localized places so it can decalcify the tooth? The answer is: It is done by acid-forming bacteria which are sheltered from the saliva by a protective bacterial over-growth attached tightly to the surface of the tooth. This sheltering over-growth is known as a plaque. It is found on the hard-to-reach places on all teeth where it can remain for months at a time undisturbed by tooth brushing.

THE RELATION OF SWEETS TO TOOTH DECAY

In about 85 per cent of us, these plaques are inhabited by types of bacteria which can form acid when they are supplied with certain food substances. This is where sweets enter the picture. Sweets belong to that class of foods known as carbohydrates. When acid-forming bacteria attack carbohydrates, one of the resulting products is acid. Some of the carbohydrates, such as starch and cellulose, are relatively difficult materials for these bacteria to convert into acid. Sugars, on the other hand, are quite easily acted on to form acid. There are several of these sugars used extensively in our everyday foods. Corn syrup, or glucose, is the one most easily made into acid. Another, and the most abundant one, is table sugar, made from sugar cane and sugar beets. It is practically a chemically pure compound. Under the action of these acid-forming bacteria, table sugar changes quickly to glucose and then to acid. Honey, maple syrup and other naturally occurring sugars are just as good acid producers as are glucose and table sugar. Hence the answer to the question, "Are natural sweets bad for the teeth?" is yes, they are.

Held and protected by the plaque on the tooth surface, the acid attacks that part of the tooth covered by the plaque and tooth decay is started.

Presented before the Section on Pediatrics at the Annual Meeting of the Ohio State Medical Association, Columbus, April 19-22, 1949.

The Author

● **Dr. Kitchin, Columbus, Ohio, is a graduate of Ohio State University College of Dentistry, 1924; professor and secretary of Dental College, Ohio State University; and associate professor of preventive medicine, Ohio State University.**

Recall that I said that about 85 per cent of people had these acid-forming bacteria sheltered in the plaques on their teeth. The remaining approximately 15 per cent are those fortunate individuals who do not have tooth decay no matter how much sweets they eat. The reason their teeth do not decay is that the kinds of bacteria capable of forming acid, do not grow in their mouths. Why this is the cause is a question which science has not yet been able to answer.

HOW DIETARY CONTROL REDUCES TOOTH DECAY

In the mouth where acid-forming bacteria are present, the consumption of sweets causes these bacteria to increase in number. If such an individual is deprived of sweets and has starches sharply reduced for a period of two weeks, these bacteria are practically starved out and we have, as a result, an artificially produced condition similar to that found in the mouths of those fortunate persons who do not have tooth decay.

This mouth condition can be maintained for periods varying from several months to several years, if the individual concerned will conscientiously avoid sweets in all forms, eating only those forms of carbohydrates known as starches and celluloses. Under such conditions, tooth decay will be reduced greatly and often stopped entirely for as long as these bacteria are under control.

When sweets in any form are taken into the mouth, acid is produced in less than a minute and continues to act on the tooth area covered by the plaque for about an hour. This introduces another factor into the sweets and tooth decay relationship. In addition to the amount of sweets consumed, the frequency of intake is an equal, if not more important, factor. Small amounts of sweets frequently consumed will total up to many hours of acid production and tooth decay. Remember that every time you eat sweets, there can be an hour's tooth decay activity. Very

small amounts of sweets are sufficient to cause this action.

LESS TOOTH DECAY IN CHILDREN DEPRIVED OF SUGAR

Despite the highly colored advertisements and pseudo scientific claims of sugar makers and candy makers, sugar is not an essential food. One does not need it to have good health. Plenty of energy can be secured from other forms of carbohydrates such as starch. The high consumption of sugar in this country, about 120 lbs. per person per year, is an outstanding cause of our extensive tooth decay, especially in children. Dental surveys of children in such areas of chronic starvation as occur in India, show much less tooth decay per capita than in the United States with our vaunted, adequate nutrition. The same thing has been shown in surveys of orphanage children here at home, where the diet was, for reasons of economy, definitely deficient in vitamins and minerals and very low in sweets of all forms. Dental surveys in Norway, Holland and Italy, immediately following World War II, showed markedly less decay in the teeth of children who had been, for years, on starvation diets (and no sweets) than is routinely found in our children on an adequate diet with high sugar content. Sugar rationing in this country, where candy is considered as a food for tax and rationing purposes, was never stringent enough to reduce our tooth decay rate. It is of current interest to note that wartime surveys of British children showed a marked reduction of tooth decay over the exceptionally high prewar condition. At present there is great rejoicing in Britain over the fact that the sweets ration is soon to be increased by a pound of candy per person per month. This is an example of a wartime scarcity which was conducive to better health than the normal peacetime condition. This lesson, like many others taught by war, is being ignored, or overlooked, or both.

The relation between the consumption of sweets and tooth decay has been recognized in an empirical and unscientific manner for many years. For instance, bakers and candy makers have long been considered liable to excessive tooth decay. It is a common observation that college students frequently exhibit a notable increase in tooth decay over what was experienced by them in high school. This correlates with a change in eating habits, in particular with the tendency to eat sweets in place of breakfast and/or lunch. In a recent survey of students at the University of California the daily consumption of sugar, in all forms (and there are many of them), was found to average as high as eighteen teaspoonfuls per day. In this survey, the activity of tooth decay was found to be directly related to the amount of sugar consumed. Those in the group which did not exceed ten teaspoonfuls per day had markedly less decay activity than those who averaged eighteen teaspoonfuls per day. This is not to be interpreted as meaning that anyone can, from the standpoint of tooth decay, safely consume ten teaspoonfuls of sugar per day. It only points out a direct relationship between sugar consumption and tooth decay.

TOOTH DECAY NOT A DISEASE OF NUTRITIONAL DEFICIENCY

There has been, and still is, much confusion regarding the relation of diet and nutrition to tooth decay. Many nutritionists, failing to understand the process by which decay of the teeth is brought about, are unintentionally adding to the confusion by advocating that tooth decay is due to dietary deficiencies. Especially is this claim made for deficiencies of minerals and vitamins. There is no experimental evidence, worthy of the name, which supports such claims. There is, at the time, much good evidence to prove these claims false. In the face of markedly reduced tooth decay in children in starvation areas in India and of a similar condition in the wartime generation of children in Norway, Holland and Italy, any claim that tooth decay is a deficiency disease is obviously unwarranted. Its relation to sweets in the diet, on the other hand, is both convincing and real.

If additional refutation of any casual relationship to vitamin and mineral deficiency is necessary, one needs only note the gigantic growth of a decade in the sales volume of vitamin and mineral preparations at the corner drug store. There has been a gradual but persistent increase in tooth decay during the same period. The sale of vitamin and mineral preparations is literally a billion dollar business, but the use of these substances has not been accompanied by any reduction in tooth decay. Actually, the incidence of tooth decay has increased during this vastly enlarged consumption of vitamin and mineral preparations by the general public.

OCCURRENCE OF SUGAR IN THE DAILY DIET

In estimating the amount of sweets consumed per day, one is apt to overlook many of the food items whose sugar content is quite high and to have little or no idea of how many teaspoonfuls of sugar are contained in normal portions of food and enter into a day's supply. All candy runs about 85 per cent sugar. A five-ounce candy bar contains about 20 teaspoons of sugar. A single Life Saver has one-third of a teaspoonful and one stick of gum is good for one-half teaspoon of sugar. Ice cream contains six teaspoons of sugar in one-eighth quart, and one quart does not serve eight persons, with what might be termed generous helpings. That bottle of Coca Cola that is advertised to give you a pick-up has four and one-third teaspoons of

sugar in it. It really gives your acid-forming bacteria a pick-up. Ginger ale supplies you with three and one-third spoonfuls and chocolate milk, served so freely to school children, has six spoonfuls to the glass. That piece of pie has from ten to fourteen spoonfuls and the heavy syrup in the canned fruit supplied for your dessert is adding three to four spoonfuls of sugar.

So generally and so generously does sugar enter into our daily food that a conscientious attempt to eliminate it from the diet in order to reduce tooth decay requires considerable effort. A careful reading of the small print on the labels of most prepared food articles will reveal sugar as an added ingredient. For those whose susceptibility to tooth decay is great, even the small amount of sugar in such daily used items as mayonnaise dressing, sugar cured meat or a sugar sweetened dentifrice may be sufficient to maintain the acid-forming mouth bacteria in large numbers. All of these things have been found responsible in individual cases for an inability to drastically reduce acid-forming mouth bacteria and thus control tooth decay.

BACTERIAL LABORATORIES FOR DETERMINATION OF DEGREE OF TOOTH DECAY ACTIVITY

In order to assist dentists in the control of tooth decay by dietary treatment, special bacteriological laboratories have been established at a number of dental schools including Ohio State University, Western Reserve University, University of Michigan and University of Pennsylvania. Some state boards of health are also active in this field, notably in Iowa and Michigan. These laboratories do not treat patients. They determine for the dentist the extent of acid-forming mouth bacteria for a patient under treatment and advise the dentist of the effects of his dietary treatment in terms of the rise or fall of the patient's acid-forming bacteria. This bacteriologic check carried on before, during, and after a carefully worked-out low carbohydrate diet regime, quickly brings out any lack of patient cooperation, or any case not amenable to such treatment because of starch being sufficient to maintain the acid-forming bacteria. A small percentage of persons fall in this latter category.

HOW AVERAGE INDIVIDUAL CAN REDUCE HIS TOOTH DECAY ACTIVITY

It is quite possible for most intelligent individuals to reduce a tendency to tooth decay by a sharp reduction of sweets in the diet. One of the first steps is to stop adding any sugar, or other carbohydrate sweetening agent, to the food at the table and to quit piecing on sweets in any form between meals. The next step is to drastically cut the cook's sugar supply. Remember that whole hour's acid production by the bacteria every time you consume sweets, even in very small quantities. Eat a good breakfast of such essential foods as eggs, milk, and unsweetened fruit, and avoid that midmorning pick-up which is usually sweets in some form. The same principle should apply to other meals.

There has been in recent months, a considerable amount of publicity concerning fluorine and dentifrices containing ammonium and urea in their relation to the control of tooth decay. Much of this has been, in my opinion, premature. Truth, there is data to support some claims for these materials, more for fluorine to date than for the ammonium-urea dentifrices, which are still in the test tube stage. The great danger lies in putting too much faith in these possible aids. A drastic reduction in the eating of sweets, especially in the frequency of eating them, will do more to reduce your tooth decay than any other method yet devised. While it is necessary to seek the aid of your dentist for the repair of tooth decay damage already done to your teeth, you have it within your own power to avoid much future need for such aid. It is your choice—turn down the sweets or take the tooth decay.

Therapeutic Exercises in the Treatment of Low Back Pain

Examination of large numbers of "muscular backs" reveals certain types of trunk weaknesses and certain relations with the pelvic tilt that are very interesting. If these different types of relative muscle deficiencies are followed it becomes apparent why no exercise "system" can answer all the questions, but why individual testing and prescription is necessary.

It is of utmost importance to give the patient a limited but well-supervised exercise program. The weak patient may have to start five-minute periods several times a day and gradually work up to one or two half-hour periods a day to obtain satisfactory results. The exercises must be performed under supervision of the doctor or therapist and, unless this is done regularly, at least two or three times a week, and followed up by daily home exercises, no results can be expected.

The following figures may illustrate that a meticulous exercise approach will yield results. Of a total of 143 patients, 92 (or 65 per cent) were found to be "muscular backs." Of these patients 71 (77 per cent) treated with therapeutic exercises were relieved of their complaints and conformed to normal muscle test standards; 11 (12 per cent) complained of occasional pain or did not quite conform to normal standards, and 10 (11 per cent) were not relieved.—Howard A. Rusk, M. D., New York State Journal of Medicine, Volume 49, No. 13, July 1, 1949.

The Office Management of Peptic Ulcer Disease

C. ROWELL HOFFMANN, M. D.

MORE than ninety per cent of the uncomplicated cases of peptic ulcer seen in office practice can be adequately treated on a proper ambulatory regime. The basis of successful treatment depends, first on a thorough study of the patient rather than a cursory history, an incomplete gastric analysis and routine roentgenological studies and secondarily on individualized therapy of a particular patient with peptic ulcer disease, instead of a standardized treatment for an ulcer lesion.

Cases complicated by perforation, hemorrhage, penetration into an adjacent viscus, or stenosis and obstruction are not amenable to ambulatory treatment.[1]

PRINCIPAL UNDERLYING TREATMENT

The fundamental underlying any successful treatment involves placing the stomach as near to complete rest as possible, while maintaining nutrition and continuous inactivation of gastric juice. Many ulcers heal without treatment in from four to eight weeks, only to recur within six months to a year, and continue with a progression of exacerbations and remissions, until irreparable damage from scarring occurs, or an acute complication requires emergency surgical intervention. The knowledge that temporary healing often occurs without treatment, or in spite of many of the treatments in common vogue, should not deter one from using the treatment that will most nearly heal all uncomplicated ulcers and minimize recurrences. Any compromise for the convenience of the patient, or any intermittent masking of symptoms with antacids, instead of complete gastric rest and secretory inactivation, is only an invitation to future trouble and an unrelieved patient. We have yet to see the patient who was unwilling to follow the most rigid of regimes, if the need for it and the physiology underlying its use, were explained to him in understandable words.

In placing the stomach at complete rest, we attempt to minimize its activity by avoiding all solids, relieving it of the burden of liquefaction, and of setting up active enough peristalsis to propel viscid or semisolid food through the pylorus. Distention, which is a stimulus to both increased motion and secretion, is avoided by more frequent, smaller feedings. The psychic stimulation of smelling or discussing food, or eating at the table with others is avoided. Continuous inactivation of both acid and pepsin are accomplished by the choice of a food of high combining power, capable of supplying adequate protein, fat, carbohydrate, and calories, and which stimulates no secondary secretion of gastric juice on absorption of its digestion products. It is important to avoid intermittent large meals early in the treatment, and equally necessary to maintain treatment more than the customary twelve out of twenty-four hours.

Submitted November 19, 1948.

The Author

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INITIAL TREATMENT

Of the more publicized treatments we have abandoned both the ambulatory regimen of Alvarez,[2, 3] and the modified Meuhlengrath[4, 5, 6] diets because of the increased burden the three larger meals place on the stomach. The Sippy program[7] offers the objections of the lack of necessity of bed rest, the common observation that ulcers heal as well on the milk alone as with the alkaline powders, and the daily additions to the diet. Amino acid feedings[8] are avoided because of the acid rebound they provoke and sole dependance on drugs because of their tendency to mask symptoms rather than heal ulcers.

In our hands, the following program adopted from Bockus[9] has offered the most gratifying results.

The patient is instructed to mix three pints of milk and one pint of cream, and add to this two tablespoons of milk sugar. During the day, a supply of the mixture is carried in a one quart thermos bottle. Every hour, on the hour, from seven a. m. until eleven p. m. the patient drinks four ounces of the mixture slowly after allowing it to warm. The last feeding before retiring is substituted by pure cream in equal amount. No other foods are allowed, except four ounces of water, mid-way between feedings as desired by the patient. For those patients who are over forty, and have a history of unusually intractable ulcer or markedly increased secretion during the second hour following the test meal the regimen is modified

by the addition of eight cubic centimeters of a mixture of aluminum hydroxide and magnesium trisilicate, fifteen minutes before each feeding, and an extra four ounces of cream at three a. m. Both initial regimens are continued from two to three weeks.

On the program outlined, an intake in excess of 3100 calories is maintained, which is well balanced in relationship, of fat, carbohydrate, and protein content. In our experience the temporary deficiencies of iron and ascorbic acid have not proven to be of clinical significance. The milk provokes a minimum of digestive activity of the stomach, and an absence of secondary secretion, combined with a maximum of neutralizing power. The rapid emptying of high carbohydrate feedings are avoided. It establishes an orderly routine for the patient without burdening his time. He is able to avoid the psychic stimulation of food.

At the end of the third day the patient is reinterviewed. Over ninety per cent of the patients who will respond to an ambulatory regimen are free of all symptoms within forty-eight hours. In selected patients it may be necessary to add the colloidal antacids and the extra cream feeding to control night pain, but this is rarely necessary.

The addition of milk sugar is usually sufficient to prevent constipation. Where it is not, substituting four ounces of prune juice for the first feeding of the mixture should be tried before resorting to heavy magnesium oxide. For the unusual individual who has a true idiosyncracy to milk, modification by the addition of sodium citrate or the substitution of a soybean product, egg albumen or gelatin are usually successful.

ADDITIONS TO DIET

At the end of two weeks a teacup of cooked cereal and four ounces of prune juice are added at eight a. m.; at noon, six ounces of cream soup made from any vegetable except tomato or onion; at six p. m., a teacup of jello, junket, or cornstarch pudding. At the end of another week, it is usually safe to go to six small feedings including toast, crackers, eggs, and beverages. Then, at one to two week intervals, first soft vegetables, then fish and chicken, and finally lamb and stewed fruits are added.

In the patient with gastric ulcer, the differentiation of benign from malignant ulcer is always of foremost importance. If typical healing, with reduction of the crater size, and the scarring with radiating folds cannot be demonstrated on careful radiological re-examination at the end of three weeks, malignant ulceration must be strongly suspected and laparotomy seriously considered. In duodenal ulcer disease it is usually sufficient to re-examine the patient at the end of eight weeks, for evidence of healing and evaluation of residual damage from scarring.

CONSIDERATION OF EXTRAGASTRIC FACTORS

In the successful management of ulcer disease, one can never lose sight of the patient as a whole and the constitutional and systemic environment in which the ulcer occurs.

Major psychosis and psychoneurosis are rarely encountered in the ulcer patient. It is seldom necessary to resort to psychoanalysis to bring out the anxieties and mental conflicts which prevent healing and precipitate recurrences. The mental purgation that takes place, when after a long relationship, the patient finally confides his problems in the physician, does much to promote healing. A more permanent solution can usually be found after healing has occurred.

Evidence of vagus overactivity as manifest by hyperchlorhydria and hypersecretion, persistant bradycardia, dermagraphia, and spasm of the large and small bowel must be carefully sought after, and where it is found to exist, modified by atropine or belladonna. Often the patient is exceeding his tolerance for tobacco, and a reduction in smoking will produce marked improvement. Where clinical evidence of hypothyroidism can be confirmed by elevated blood cholestrol, and lowered basal metabolic rate, thyroid extract should be administered.

Systemic disorders must be carefully sought out, and when present be given due regard. Malnutrition, lowered serum protein levels, chronic anemias, and manifest vitamin deficiencies must be corrected to accomplish proper healing. Allergies require attention to avoid foods to which the patient is sensitive. This has already been briefly mentioned. The patient must be cautioned as to the adverse effect of respiratory infections, and when present, the use of coal tar analgesics must be avoided. While proven ulcerative syphilis of the stomach is rare, it is not at all uncommon to encounter the coexistence of peptic ulcer refractive to treatment, and then observe rapid healing after antiluetic therapy is initiated. Due recognition must be given to advanced arteriosclerosis in the elderly patient. Delayed healing is often due to sclerotic arteries. It is usually necessary for the older arteriosclerotic with ulcer disease to spend the remainder of his life on a soft, bland, frequent-feeding diet if recurrence with penetration into a sclerotic vessel incapable of retracting are to be avoided.

Definite foci of infection should be sought in the sinuses, tonsils, apical abscesses, gallbladder, and prostate. Because of the possibility of a reaction capable of precipitating hemorrhage

or penetration, it is inadvisable to eradicate them during periods of ulcer activity. If foci are thought to be significant, they should be treated after the active ulcer has healed.

HOSPITALIZATION

While it is not essential to hospitalize the great majority of patients with active, uncomplicated peptic ulcer disease, there is no contraindication to doing so. The suspicion, however, of the development of a complication demands immediate hospitalization. The indications are: (a) Tarry stools, hematemesis, or persistant strongly positive occult blood reaction; (b) the replacement of rhythmic ulcer pain by constant pain; (c) transition from circumscribed epigastric pain to pain radiating to the back or elsewhere; (d) uncontrollable night pain or vomiting; (e) gastric retention; (f) a suspicion of impending perforation. It may be advisable to hospitalize patients who are oversensitive to pain, those with extreme anxieties, and the patient in whom poor results are obtained because of lack of cooperation.

PREVENTION OF RECURRENCES

Prevention of recurrences is as important as treatment of the active ulcer. It is the duty, during the course of treatment, of every physician, to familiarize the patient with the natural history of the disease, and the likelihood of recurrence. While the patient will become symptom free almost immediately on the treatment outlined, and remain healed from six to twelve months, at least half will have recurrent ulceration within five years, unless subsequent management is carefully planned. It is advisable to protect the upper digestive tract during the first year, by three small extra feedings of milk in the midmorning and afternoon. It is essential that prolonged hunger be avoided, and that fried foods, and condiments be indulged in sparingly. The sources of anxieties and overfatigue must be removed, smoking kept within the patient's tolerance; and injurious ingestion of alcohol lessened. During periods of emotional crisis, the patient must resort to a more strict dietary program. Every effort must be made to determine the circumstances under which the immediate ulceration occurred, and their repetition avoided. Todate, insufficient proof that either hisidine or entragastrone will prevent any more recurrences than careful management alone has been shown, and until it is, we do feel that our patients need not be the guinea pigs for an expensive and discomforting experiment. All patients must be instructed in the recognition of the symptoms of ulcer disease and its complications. In the event of reactivity, they must immediately revert to their original strict diet, and seek medical aid.

SUMMARY

Most uncomplicated peptic ulcers are amenable to ambulatory treatment. A regimen to heal such ulcers is outlined. The constitutional and systemic factors important in patient management are listed. The prevention of recurrences is stressed.

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Psychogenic Aspects of Allergy

Some aspects of medicine, like styles, seem to run in cycles. Prior to the era of bacteriology, the theories of the nervous origin of diseases were frequent in vogue. Medicine as a whole is now in a "psychosomatic" whirl, and allergy is drawn into the maelstrom with many other diseases; for example, rheumatism. As we approach the hobbleskirt in extremes, then perhaps we will revert to normal again in allergy as in styles.

Patients with long standing allergies naturally go through a nervous strain and the seeming endlessness of some allergic conditions stretch this very near to the breaking point. But is this a pattern of allergy or is it a characteristic of all diseases?

Several years ago we were led to believe that allergic individuals were far above the intelligent quotient and that they were highly strung and that allergy was never found in the insane. All of this was pleasing to the allergic patient. Now we know this is not altogether true.

Is this psychiatric manifestation of many diseases a new born babe of the science of medicine, or is it just the "new look" so to speak? The Greeks learned centuries ago from the barbarian Tracians that the body could not be cured without the mind, thus psychosomatic medicine is nothing new, but is centuries old.

Allergy, being a comparatively new specialty, caught the public fancy some years ago and as a result became the waste basket for most of the undiagnosable conditions.—J. A. Blue, M. D., Oklahoma City, Okla. Jrn. of Oklahoma State Med. Assn., Vol. 42, No. 7, July, 1949.

Porphyria

JOSEPH M. HAYMAN, JR., M. D.

A MAN, 47 years old, who had been discharged from the Army after three months' service and who had previously been in good health, was admitted to a hospital on January 25, 1948, for a hydrocelectomy. He was given mild doses of barbiturates for the two postoperative nights and on the third day complained so bitterly of abdominal pain and obstipation that an exploratory laparotomy was performed in the belief that he had an intestinal obstruction. Following this operation he became quite delirious, hysterical, and fearful. A diagnosis of toxic psychosis was made.

He was transferred to a psychiatric ward where interviews disclosed many psychological conflicts, the chief of which involved difficulties with his wife. He developed a flaccid quadriplegia with loss of reflexes. Spinal fluid, urine, and blood counts were reported as entirely normal. His paralysis gradually improved, reflexes returned, and he was discharged with a diagnosis of conversion hysteria.

During the summer he was quite well, able to play golf, and do light work. The first of August he developed an acute tonsillitis for which he received sulfadiazine and sodium seconal. The tonsillitis improved in forty-eight hours but he developed abdominal pain, nausea, vomiting, backache and weakness in his extremities. When hospitalized he was confused but oriented as to time and place. His speech was mushy and difficult to understand. The reflexes in his arms were present but diminished, and absent in his legs which he could scarcely move. Abdominal and cremasteric reflexes were absent. There were no pyramidal or posterior column signs. Routine urine and blood examinations were again normal as was his spinal fluid. By September 10, he was completely irrational, with a flaccid quadriplegia, inability to swallow and difficulty in speech. By the first of December he had shown gradual improvement, was able to talk, to eat fairly normally, and some power had returned to both arms and legs although reflexes were still absent.

A 22-year-old woman was admitted to the hospital on June 9, 1945. As a child she had been in good health except for the usual childhood diseases. At 18 she had had a peculiar attack of nausea, vomiting, abdominal pain, and muscle weakness which lasted about one month and from which convalescence had been slow. One year later she had an attack of acute pyelitis for which she was given a sulfa drug. The acute symptoms subsided promptly but she was irritable, sluggish and not herself for some weeks. She had another bout of severe crampy abdominal pain one year later which, however, only lasted a few days. At the age of 21 she had still another bout of abdominal pain and was treated for pyelitis.

Some weeks later she was admitted to another hospital in a highly nervous state complaining of severe colicky abdominal pain associated with marked constipation. She had not had a bowel movement for 13 days. She complained of severe pains in her arms and legs associated with weakness. Her behavior was that of hysteria. Blood pressure was recorded as 170/120 and her heart rate rapid. After two weeks of observation, no diagnosis could be made and she was sent home. She continued to grow worse and was readmitted complaining of abdominal colic, constipation, pains in her arms and legs associated with weakness. She had spells of losing consciousness for two or three minutes at a time three or four times a day. She was finally diagnosed as conversion hysteria and again sent home.

During the following three weeks she gradually developed increased difficulty in walking and became more and more of a hysterical problem. Following a rather severe convulsion she lost her hearing, had aphonia and marked blurring of vision for four hours. On admission to the University Hospitals she was hysterical with severe outbursts of temper followed by sobbing spells. There were insomnia, periods of negativism, and complete lack of cooperation. She appeared acutely ill. Her temperature was normal. Blood pressure was 210/100, heart rate 120. She complained of severe abdominal pain and constipation. The abdomen, however, was soft. There was marked weakness of the muscles of her hands, arms, and legs which

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progressed in a period of about three weeks to almost complete flaccid paralysis with absence of tendon reflexes. There was no sensory disturbance. Routine examinations of blood and urine were normal. Spinal fluid was completely normal. Blood urea nitrogen, cephalin flocculation tests, serum proteins, calcium, phosphates, sugar, and icterus index tests were all normal. X-rays of the colon, urinary tract, skull, and lungs were normal. Electrocardiograms and electroencephalograms were normal.

About July first she began to show some improvement. Her blood pressure and heart rate returned to normal. Abdominal pain and constipation disappeared. She left the hospital August first able to sit in a wheel chair. Improvement was very slow, however, and it was not until May, 1946, that she was able to take a job in a department store calling for light work.

In each of these cases, after considerable delay, the urine was tested for porphyrins and porphobilinogen, and the diagnosis of porphyria was established. If it had been made earlier, one patient would have been spared a laporatomy, and the other a long period of psychotherapy. In both the period of incapacity might well have been greatly reduced by avoidance of toxic or possibly toxic drugs.

The average physician confronted with the subject of porphyrin metabolism "pictures either a bewildering complex group of strange pigments obtained from stools and urine, or an exceedingly rare disease characterized by sensitivity to light and acute abdominal pain."[1]

There is, however, another condition, represented by the two cases quoted, and usually known as acute porphyria which while not common is more frequent than is generally recognized, and which is readily recognized if the possibility is kept in mind. I knew nothing about the condition, and had never recognized a case until a house officer made the diagnosis on a patient in the medical wards of the University Hospitals before the war. Since then, two additional cases have been recognized at the University Hospitals, and four at the Crile Veterans' Administration Hospital.

CHEMISTRY

Before taking up the picture of acute porphyria, it might be well to review briefly an outline of pyrrole metabolism.[2] Porphyrin derivatives are part of the respiratory enzymes in all living cells. They form an essential part of hemoglobin, myoglobin, catalase, peroxidase, and the cytochrome of animals and chlorophyl of plants.

The basic structure of the porphyrins consists of 4 pyrrole rings linked together by 4 methene bridges, and containing 8 replaceable hydrogen atoms. If these 8 hydrogen atoms are replaced by 4 methyl and 4 ethyl groups, there are 4 different arrangements which are possible, giving 4 isomers. These have been called arbitrarily Types I, II, III, and IV. These 4 methyl-ethyl substitution products do not occur in nature but are the basic structures to which the porphyrins are referred for purposes of identification. That is, if a compound has or can be transferred to a compound having a 1, 3, 5, 7 and 2, 4, 6, 8 arrangement of substitution groups, it is referred to as a Type I porphyrin. There is no known way in which a porphyrin of one type can be transformed into another type, either in nature or in the laboratory, without a complete breakdown of the pyrrole ring and a resynthesis. All the naturally occurring porphyrins so far discovered have been found to correspond to etioporphyrins Type I and III.

If the 8 hydrogens are replaced by three types of substituting groups, 15 isomeric compounds are theoretically possible, but each corresponds in arrangement of the substitution groups with one of the four types of etioporphyrins.

If the 8 hydrogen atoms are replaced by 4 methyl, 2 propionyl, and 2 vinyl groups, compounds are obtained which are called protoporphyrins. The porphyrin in both hemoglobin and myoglobin, as well as the prosthetic group of other respiratory enzymes, is a protoporphyrin.

Under certain conditions porphyrins can be isolated which have 4 propionyl groups instead of 2 propionyl and 2 vinyl as in protoporphyrin. These compounds are called coproporphrins because they were first isolated from the stool by Hans Fisher. Both coproporphyrin I and III have been isolated from human material. If the 4 methyl groups of a coproporphyrin are carboxylated a compound is formed called uroporphyrin, which is apparently always pathological.

The exact steps in the natural synthesis of the porphyrins are unknown, but it is assumed that it starts with very simple building stones. Fisher has suggested that possibly aceto-acetic acid may be one of the sources, and others have suggested proline, oxyproline, or tryptophan. The next step is believed to be the formation of substituted pyrroles or pyrromethenes which are then condensed to porphyrins. Since one type of porphyrin cannot be changed into another, Fisher suggested that the two types found in nature are synthesized synchronously but independently.

The individual porphyrins will be formed in relatively different amounts according to the conditions of synthesis and the relative amounts of different substituted pyrromethenes which take part. Under normal conditions porphyrin

synthesis is directed to the formation of relatively large amounts of Type III and small amounts of Type I. Type I porphyrins cannot be used and so are excreted, partly in urine, but chiefly in the stool, the total amounting to some 226-376γ per day.

Under certain conditions there may occur an orderly increased or decreased formation of Type III porphyrins associated with a simultaneous increase or decrease in Type I production. Under other conditions this constant ratio may be disturbed with a resultant disorderly increased formation of Type I compounds, or with the production of abnormal porphyrins as in cases of congenital porphyria.

In spite of the importance of protoporphyrin, the amount present as such must be very small, and it is not increased in the breakdown of hemoglobin. Apparently before iron is released from heme, the porphyrin ring is broken giving a chain compound, as bilirubin, which lacks all of the characteristic properties of the porphyrin ring. The relation of protoporphyrin to the coproporphyrins and uroporphyrins which are present in increased amounts in disease is obscure. It would be convenient to assume that under pathological conditions the degradation of protoporphyrin might some how be by way of coproporphyrin which would involve transformation of two vinyl groups to propionic, and then by carboxylation to uroporphyrins. But no satisfactory evidence that this occurs has been obtained either by perfusing protoporphyrin through the liver or injecting it into the intact animal. Hence, we are left with the alternative hypothesis that small amounts of coproporphrin, whose normal function, if any, is unknown are formed as by-products of the synthesis of protoporphyrin, and that in disease the production of by-products is increased.

There is a considerable increase in the excretion of porphyrins in a number of diseases. As long ago as 1887 Huppert[3] reported an increase of porphyrin excretion in fever and this has been repeatedly confirmed. Many observers have noted increase in the urinary porphyrin in liver disease,[4] pellagra, and in a number of skin diseases. The largest amounts, however, are excreted by patients with hemolytic jaundice. Distinct increases are also encountered in pernicious anemia during the period of reticulocyte response to liver therapy.[5] Since in all of these instances, or nearly all, the increase has been in coproporphyrin I, it is more probably related to increased hemopoietic activity than to blood destruction.

LEAD POISONING

Perhaps one of the most important findings in the study of porphyrin metabolism has been the demonstration of increased porphyrinuria in lead poisoning.[6] This has been identified as Type III rather than Type I. Van den Bergh[7] administered lead salts to human beings and observed increased urinary porphyrin excretion after two to twelve days. It is interesting to speculate whether some of the symptoms of lead poisoning, particularly the colic, may not be mediated through the disturbance of porphyrin metabolism. This increased porphyruria is apparently not related to an abnormal route of blood destruction, for Kark and Meiklejohn[8] injected solutions of hemoglobin into patients with lead poisoning and found that it was eliminated in the normal way, as bilirubin and urobilinogen, and not as porphyrins. Thus, the increased porphyruria must probably be attributed to an altered synthetic process in the formation of hemoglobin. Rimington[9] and Watson[6] have suggested that lead interferes with the introduction of iron into protoporphyrin, which then becomes side-tracked during synthesis and excreted as coproporphyrin III.

Increased porphyrinuria may also occur after certain drugs, particularly sulfonal, trional, salvarsan, alcohol, sulfonamides, and barbiturates.[10]

PORPHYRIA

The most interesting disturbance in porphyrin metabolism is porphyria which may be defined as a primary idiopathic disease characterized by a marked over-production of porphyrins so that the amounts occurring in the urine are sufficient to produce gross changes in color, or at least changes in color after exposure to light. The term "porphyria" is preferred to "porphyrinuria" because the feces frequently contain even more porphyrins than the urine, and because there may be porphyrinuria in many diseases apparently unassociated with symptoms. The older term "hematoporphyrinuria" should be discarded because the pigment is not hematoporphyrin which is an artificial product formed when hemoglobin is treated with sulfuric acid and does not occur in nature.

From the clinical standpoint porphyria is usually divided into two types: (1) the congenital, light sensitive, and (2) the so-called acute porphyria, represented by the two cases quoted.

CONGENITAL PORPHYRIA

Congenital porphyria is the rarer form of the disease. Turner and Obermayer[11] found record of 86 cases prior to 1936, and there have been but few additional cases recorded since. Garrod[12] included it among his "inborn errors of metabolism" and believed that it was transmitted as a mendelian regressive characteristic. Symptoms may be present at birth, or develop during childhood. With rare exceptions the earliest symptom is the red color of the urine. There may be a reddish discoloration of the teeth,

reddish deposits in the bones, and sensitivity of the skin to light.

The sensitivity to light is manifested by itching and burning of the exposed skin surfaces, frequently associated with photophobia and often an outspoken but not suppurative conjunctivitis. There may be a diffuse hyperemia and edema of the face within a few hours after exposure, followed by a vesicular or bulbous eruption. The eruption is called hydroa vacciniforme, hydroa aestivale or recurrent summer eruption by the dermatologists. If uncomplicated, a crust forms over the lesions, and healing occurs with relatively little, though definite scarring. Secondarily infected bullae often ulcerate and are responsible for marked scarring and deformity. These attacks recur at least annually, most often beginning in the spring, and recur through the summer unless particular care is taken to avoid the sun's rays. While some cases of hydroa aestivale are said to improve after puberty and not to be associated with porphyria, it is probable that the relationship has escaped notice in many instances. Later in the course of the disease anemia and splenomegaly may develop, and there may be marked deformity of ears, nose, face, and fingers. Diagnosis rests on examination of the urine which contains large amounts of uroporphyrin I and coproporphyrin I, the majority or all being in the free state, which apparently is essential for photosensitization. According to Watson the urine does not contain porphobilinogen.

ACUTE PORPHYRIA

Acute porphyria, represented by the two cases quoted, is much more common than the congenital type. In spite of the fact that it has been recognized for many years, and that over 250 cases had been reported by 1939,[13] and that there have been an increasing number of reports in the literature in the past four years, the disease is rarely considered in differential diagnosis.

Acute porphyria is in reality a chronic condition, probably also congenital but inherited as a mendelian dominant.[14] The symptoms appear later in life, usually during the third and fourth decades, and have been reported more commonly in females, the ratio of women to men being about 3:1. The classical symptoms are cramp-like abdominal pain, constipation, weakness or paralysis of the extremities, and mental symptoms varying from mild irritability to a frank psychosis.[15]

The patients frequently give a history of an assortment of ill-defined complaints including vague, poorly localized abdominal pain, bizzare pains in the extremities or elsewhere, nervousness, insomia, depression, and generalized or localized weakness. The urine may perhaps have been noted to be unusually dark or red at times. Frequently there will be a history of ingestion of some drug, especially one of the sulfonamides or a barbiturate. This led to the separation of so-called acute idiopathic from supposed acute toxic cases. But the symptoms in these two groups are identical, and so far as is known, the types of porphyrins excreted are the same. Waldenström[16] believes that both groups are the same, and that the condition is a hereditary defect in pyrrole, but not necessarily in porphyrin metabolism. A drug then is at most the precipitating factor in a person who carries the taint. Certainly the frequency with which abnormal pigments are found in the urine of symptom-free members of patients' families lends support to this view.

SYMPTOMS

The acute episode, as in the two case histories, is characterized chiefly by gastro-intestinal disturbances and involvement of the central nervous system. In milder attacks the gastro-intestinal symptoms predominate. There is severe cramp-like abdominal pain which may be generalized or confined to the lower abdomen or to the region about the umbilicus. Constipation is usually marked. Nausea and vomiting are frequently severe. Fever and leucocytosis may or may not be present. In contrast to the symptoms, so typical of an acute surgical condition, when the abdomen is examined there is no rigidity, rebound phenomenon is absent, and the tenderness, which is generalized, is not as marked as would be expected from the complaints. Hypertension during the attack, with return of the blood pressure to normal in a remission is commonly observed. Transcient electrocardiographic changes have been described, consisting of an elevated ST segment in Lead I and slurring of the ST segment in Lead III. Gastro-intestinal X-ray may show dilatation of segments of the gastro-intestinal tract, usually duodenum, terminal ileum or colon.

The involvement of the central nervous system may be manifest by symptoms varying from paresthesias and vague pains in the extremities to flaccid paralysis, irritability, hysterical outbursts, or delirium with hallucinations of vision and hearing, epileptic seizures and coma. The most common type of neurological involvement is an ascending, Landry's type of paralysis. Frequently the knee jerks are absent, but the Achilles present. At times absent reflexes can be elicited by repeated tapping. The intensity of the tendon reflexes may vary greatly from day to day. These nervous symptoms may appear suddenly or over the course of weeks. Respiratory failure is a common cause of death.

The neurological manifestations may suggest

a multitude of possibilities, the most confusing probably being the Guillain-Barré syndrome. In this, however, the spinal fluid contains an increased amount of protein, while in porphyria it is normal.[17]

The mental disturbance may resemble a toxic psychosis, hysteria, or a manic depressive type of reaction. Noisy delirium may alternate with marked apathy. Both Roth[18] and Schneck[19] have written on the neuropsychiatric aspects of porphyria and pointed out that many of these patients are regarded as psychoneurotic for months or years before the diagnosis is made. Roth even goes so far as to state that the disease "occurs with special frequency, if not exclusively, amongst people with severe neurotic personality disorders." He postulates that psychoneurosis plays an important part in the pathogenesis. This is difficult to reconcile with the familial incidence of the trait, and with the extensive changes in the central nervous system found at autopsy. It would seem more likely that an abnormal metabolism of nervous tissue was responsible for the hysterical and psychotic behavior. Nor does his inclusion of psychoneurotics without porphobilinogen in the urine as examples of "porphyria without porphyrinuria" seem justified. That the psychiatrists might run a few more urine analyses before embarking on extensive psychotherapy seems eminently sound.

PATHOLOGY

At autopsy the principal changes are found in the liver and in the central nervous system. The liver frequently shows accumulation of a yellowish non-iron containing pigment in the Kupfer cells[20] and apparently at times also in the parenchymal cells.[21] Areas of focal necrosis have also been described.

The changes in the central nervous system are variable. In some the brain has appeared to be normal, in others degeneration of the Purkinje cells in the cerebellum, and pigmentary degeneration of cortical cells have been noted. Some cases show areas of focal necrosis about the small blood vessels, or pigment ladened cells in the perivascular spaces and walls of blood vessels. The cord usually shows degeneration of the anterior horn cells, less often in the cells of Clarke's column. The peripheral nerves show varying degrees of demyelinization, diffuse degeneration of the nerve fibers themselves, with no inflammatory reaction or increase in wandering cells.

Changes are described in the sympathetic ganglia and attempts have been made to relate these to the hypertension, oliguria, and tachycardia which frequently accompanies the acute attacks. Others believe that the vascular symptoms as well as the intestinal cramps are more directly due to the effect of porphyrins on smooth muscle.

The prognosis of acute porphyria during an exacerbation should be extremely guarded. In the presence of neurological symptoms the mortality is probably 80 to 90 per cent. Of 100 patients who were the subject of a report by Waldenström 20 died within one year following the appearance of the disease clinically, two lived eight years, while one had lived 27 years.

The urine in acute porphyria contains variable amounts of uroporphyrin I and III besides coproporphyrins. These are all or nearly all present as zinc complexes which would account for the lack of light sensitivity, since the metal complexes of the porphyrins are not photosensitizing.[22] The amount of porphyrin in the urine varies considerably from time to time, and with the reaction of the urine. At times it is reddish when voided, at other times only darkens on exposure to light. Irrespective of these changes the urine in acute porphyria, and in those who carry the trait, although symptom-free, nearly always contains another abnormal compound called porphobilinogen whose exact structure is not known but is believed to be a substituted pyrrole compound.

PORPHOBILINOGEN

Porphobilinogen reacts with Erlich's reagent to give a colored aldehyde, just as urobilinogen, but differs from it and from indole compounds in being insoluble in chloroform. Porphobilinogen is easily tested for.[23] To 1 cc. urine add 1 cc. Erlich's reagent, 2 cc. saturated sodium acetate, and shake. If a pink color develops, add 2 cc. chloroform and shake vigorously. If the color is due to porphobilinogen it will not be extracted from the watery phase. Hammond and Welcher[24] carried out the test on 1,000 miscellaneous patients and did not encounter any false positive reactions.

Waldenström and Vahlquist[25] believe that this is the essential abnormal metabolite in acute porphyria, and that porphyrin is probably never excreted as such through the kidney in this condition, but is formed in the urine by condensation of 2 molecules of porphobilinogen, this condensation depending on temperature and pH. If 2 molecules of porphobilinogen condensed to a ring, a porphyrin would be formed; if they condensed in a chain, porphobilin, a urobilinoid pigment would be formed. Ingestion of alkali renders the urine of normal color, but does not affect the excretion of porphobilinogen, but only its rate of change to porphyrins and porphobilin. This view is opposed by Prunty[26] who was unable to recover any porphyrins in rabbits' urine after injecting porphobilinogen. Watson believes that the porphyrin in acute cases which Waldenström has called uroprophyrin III con-

sists of a mixture of uroporphyrin I and other as yet unidentified compounds.

TREATMENT

There is no known specific treatment for this metabolic defect. Its recognition, however, is important in order that the patient may be spared unnecessary surgery or prolonged psychotherapy, and in order that factors believed to precipitate attacks may be avoided.

Nilsson[27] believes that acute infections themselves may precipitate attacks. Hence, such efforts as are possible to avoid exposure to infections are in order. Since a number of drugs, especially the sulfonamides and barbiturates seem important at least as trigger agents these should be avoided. Indeed, in reading a number of the case histories, in addition to two of our own, there is at least basis for the suspicion that a relatively mild intestinal attack may have been converted into a severe one with neurological manifestations by the ignorant use of drugs.

In treatment of the acute attack, the abdominal cramps are not relieved by atropine. Nicotinic acid has been claimed to be of benefit, and its usefulness denied by other observers. Prostigmine has been reported of value as have calcium salts.

Supportive treatment during the periods of paralysis, with use of a respirator if necessary, aspiration of mucus from trachea, and treatment of bronchopneumonia may tide the patient over. After the acute episode physical therapy, including regulated passive and active exercises and massage are of value.

CONCLUSIONS

Acute porphyria should be considered in the differential diagnosis of any case of unusual abdominal complaints, or of symptoms referable to the central nervous system, particularly when these occur together. If the possibility is kept in mind, it is probable that many more cases will be recognized than have been in the past.

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Contact Dermatitis Due To Topical Anesthetics

The presence of other eczematous diseases makes the individual more susceptible. Rough dry skin and moist fine skin also do this. Sulzberger and Rostenberg submitted evidence to show that persons affected with recent or active eczematous dermatitis of contact type, were more susceptible to sensitization through external application of certain simple chemical substances, than were non-eczematous individuals. Cutaneous anesthetics become fixed or adhere to the horny layer and thus maintain a prolonged contact with the epidermis, with subsequent prolonged reaction.

In many cases immediate relief to a severe itching is desired. One is loath to withold the use of an effective medicament. Certainly, a topical anesthetic is valuable, but it should be restricted to a non-eczematous process. It should be administered for a short time only, since use for more than one week will often lead to sensitization.

Patch testing should be done before treatment of chronic dermatitis because of the chance that sensitization may be present. This simple procedure will often save weeks of disability and discomfort.—Max Braitman, M. D., Jrn. of Med. Society of N. J., Vol. 46, No. 6, June, 1949.

The Care of Hand Injuries: III Surface Injuries

I. The first-aid care of wounds of the hand is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. The best first-aid management consists of the application of a sterile protective dressing, a firm compression bandage and immobilization by splinting in the position of function.* No attempt should be made to examine, cleanse, or treat the wound until operating room facilities are available.

II. Early definitive care requires thorough evaluation of the injury with respect to its cause, time of occurrence, status as regards infection, nature of first-aid treatment and appraisal of structural damage. For undertaking the definitive treatment the conditions required are a well-equipped operating room, good lighting, adequate instruments, sufficient assistance, complete anesthesia and a bloodless field. The treatment itself consists of aseptic cleansing of the wound, removal of devitalized tissue and foreign material (exercising strict conservation of all viable tissue), complete hemostasis, and the repair of injured structures, to be followed by protective dressing to maintain the optimum position. After-treatment consists of protection, rest and elevation during healing, and early restoration of function by directed active motion.

III. Surface Injuries: Burns, abrasions and avulsions may cause destruction and denudation of any area of the skin of the hand. The care of such injuries has three major objectives:

1. Protection from infection.
2. Early restoration of skin covering.
3. Avoidance of disabling scarring and contractures.

These objectives are sought in the various stages of treatment.

1. First-aid treatment
   (a) Chemical burns.
   Remove chemical by profuse irrigation with water, preferably warm.
   (b) Heat burns, abrasions and chemical burns (after washing away the injuring agent).
   Apply sterile dressing completely to cover the hand and bandage firmly.
2. Definitive treatment.
   This should be carried on in operating room under conditions of strict asepsis.
   (a) Gentle removal of first-aid dressing, soaking loose with normal saline solution if necessary.
   (b) Gentle cleansing of injured surface by light sponging with saline on cotton balls. If surface is dirty or greasy, it may be gently cleansed with sterile neutral soap, in sterile water or bland detergent. Loose fragments and tags of skin are removed. Blisters are not opened.
   (c) Sterile strips of fine-mesh vaseline-impregnated gauze are smoothly applied to the injured surface. These are covered with dry sterile gauze, gauze being placed between adjacent fingers. The whole hand is covered with a thick layer of sterile mechanic's waste or fluff gauze, and splinted in the position of function. Elastic knit bandage is applied over all, including all fingers, with firm even pressure. The hand is kept elevated.
3. Subsequent dressings.
   The original dressing is left undisturbed for twelve to fourteen days unless elevation of temperature suggests active infection requiring inspection. The second, and all subsequent dressings until healing, are done under completely aseptic conditions.
   (a) The dressing is removed. Slough and debris are washed away by irrigation with normal saline solution (no scrubbing of surface).
   (b) Granulating areas from which slough has separated should be covered with thin split-thickness skin grafts.
   (c) Dressing, similar to that employed at first definitive treatment, is applied. Hand is splinted in position of function.
   (d) Further dressings, similarly conducted, are done at intervals of seven days until epithelization of burned surface is complete. Skin coverage by grafting should be secured as rapidly as possible, as the best assurance against infection, inflammation, infiltration, scarring and contractures. This early coverage by "skin dressing" is of the greatest importance, even when epithelization from the margins is proceeding satisfactorily. Split-thickness grafts are best for this purpose.
4. Restoration of function.
   As soon as epithelization of burned surfaces is complete, directed active use and exercise of the hand is begun. Normal use of the hand is encouraged and voluntary exercise and appropriate occupational therapy prescribed.

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* Position of function or position of grasp: wrist hyperextended in cock-up position; fingers in mid-flexion and separated; thumb abducted and in mid-flexion, with tip pointing toward little finger.

Abdominoperineal Proctosigmoidectomy for Cancer of the Lower Bowel; Incidence of Local Recurrence

HARRY E. BACON, M. D., and GEORGE D. VAUGHAN, M. D.

SINCE the rationale of surgical procedures to eliminate colostomy has been repeatedly questioned particularly in regard to their radicality, it is deemed appropriate to review the incidence of local recurrence following abdominoperineal proctosigmoidectomy for cancer of the rectosigmoid and ampullary rectum. As may be observed, the results compare favorably with those reported by other investigators on which premise it is our contention that this technique warrants comparative evaluation of its applicability. Our approach to the surgical management of lower bowel malignancy may be described briefly as follows:

A. Cancerous growths which involve the upper and middle thirds are extirpated with immediate re-establishment of intestinal continuity, or by an exteriorization procedure, such as the Mikulicz-Rankin modification.

B. Those which involve the lower sigmoid, rectosigmoid and ampullary rectum are removed by the technique of abdominoperineal proctosigmoidectomy without colostomy and with preservation of the sphincter musculature.

C. Those which involve the anal canal and lowest three centimeters of the rectum are excised by the technique of Miles with the formation of a permanent abdominal colostomy.

Our experience is based on a personal series of 723 patients with malignancy of the lower bowel of which number 585 were resected by various methods.

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consider the incidence of local recurrence and in this regard, those in group B, namely abdominoperineal proctosigmoidectomy without colostomy and with preservation of the sphincter muscle, will serve as a basis. Of the 375 patients submitted to this technique, only 76 were submitted to resection more than five years ago. To compute the percentage of local recurrence, it is customary to subtract the number of operative deaths and the number of palliative resections (liver metastases) from the total number of resections and divide this figure into the number of local recurrences. Of the 76 patients who had been resected five years ago, it is known that 27 died of cancer, but only 12 disclosed evidence of local recurrence. Four of the 27 showed liver metastasis at the time of resection and therefore may be properly labeled "palliative resections." The remaining 23 cases were resected

TABLE I

Authors' Series

	Type of Resection		No. Cases	No. Deaths	Mortality
A.	Sigmoidectomy—Multiple Stage	Mikulicz-Rankin	38	3	7.8%
	Sigmoidectomy—Single Stage	Open or closed	32	2	6.2%
	Sigmoidectomy	Hartmann	17	1	5.8%
B.	Abdominoperineal proctosigmoidectomy without colostomy and with preservation of sphincter musculature.		375	18	4.8%
C	Abdominoperineal excision—One stage—Miles		86	3	3.4%
	Abdominoperineal excision—Two stage—Lahey		7	1	14.3%
	Colostomy & Perineal excision—Lockhart-Mummery		26	1	3.8%
	Perineo-abdominal excision—Gabriel-Turner		2	0	0
	Perineal resection—Cuneo-Seneque		2	0	0
		Total	585	29	4.9%

It should be mentioned that our resectability rate computed on the number of cancer patients submitted to operation is 88.8 per cent.

In this discussion, our primary purpose is to

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with the hope of cure, but included both the favorable group (no metastasis to glands or local extension), and the less favorable group (metastasis to glands and/or local extension). There were five operative deaths. The summation of the operative deaths (5) and the palliative resections (4), namely 9, subtracted from the total 76 and divided into 23 (non-palliative resections) gives an over-all recurrence rate of 34.3 per cent. As previously mentioned there were 12 instances of local recurrence, an incidence of 17.9 per cent of the patients on whom resection was performed more than five years ago. As may be recognized the perineal anus enables the early detection of a pelvic recurrence by palpation. It may be recalled that Babcock[1] detected a recurrent nodule in six instances which were excised at a relatively early stage. Three of these patients lived without palpable recurrence from two to over four years after the secondary operation. Babcock remarks, "Without the diagnostic advantage of the perineal opening, such recurrences may reach an inoperable stage before recognition."

REVIEW OF CASES WITH LOCAL RECURRENCE

In reviewing the records of these 12 patients presenting local recurrence, one of us (G. D. V.) tabulated the location of the original growth, the gradation of the tumor, and the extent of circumferential involvement as recorded in the accompanying table:

TABLE II

No. local recurrence		12
Incidence		17.9
Gradation	I — 0	
	II — 8	
	III — 3	
	IV — 4	
Location	2 at 10 cm.)	
	2 at 9 cm.)	
	1 at 7-8 cm.)	Measured from anal margin
	2 at 6 cm.)	
	5 at 4-6 cm.)	
Circumference	7 listed as complete	
	2 listed as ½ (posterior wall)	
	1 listed as ¼ (grade IV posterior wall)	
	2 not listed	

It will be noted that in seven cases, the lower margin of the primary growth was located at or below the six centimeter level. As a result of the more recent histologic investigations by Gilchrist and others,[2, 3, 4, 5, 6] it must be admitted that these seven cases, performed more than five years ago, were incorrectly selected for sphincter muscle preservation.

Wangensteen has called attention to the observation that ordinarily the local recurrence is not primarily at the site of anastomosis, but outside of it, extending into the bowel secondarily which suggests lateral invisible spread. In this view we concur for which reason proctosigmoidectomy or any sphincter preserving technique is never employed where the lower border of the growth is at or below the six centimeter level from the anal verge.

DISCUSSION OF RECURRENCE

The subject of recurrent cancer and particularly local recurrence is interesting but it presents a problem difficult of accurate evaluation. In reviewing the literature in native and foreign tongues one is impressed with the scarcity of published reports on recurrent cancer. As Webster states, "No one cares to write much on recurrence for this admits at least partial failure and suggests incomplete operation which may be permissible for palliation but not if intended as a curative measure."

In the appended list is the percentage of recurrence as tabulated by various foreign surgeons.

Author	Per Cent Recurrence
Miles	29.5
Schneider (curative cases)	21.0
Rotter	27.8
Chaput (curative cases)	12.0
Schede	25.0
Lexer	25.0
Poppert	28.0
Mandl & Pacher	27.0
Pichler & Prutz	11.0
Davies	16.6
d'Allaines (resection)	7.0
d'Allaines (amputation)	29.0

As will be noted, little information can be gained therefrom. Nor is the following data very enlightening. For example, Peters and Colmer[14] in a group of 30 cases found recurrences to be 9 per cent in the cellular tissue, 50 per cent in the regional glands, 3 per cent in distant glands and 40 per cent metastasis to different organs.

Hartmann in a series of 65 cases operated upon by the perineal route noted 19 instances of recurrence of which 3 were pelvic and 2 distant. In another group in which the same author utilized the combined operation, a recurrence rate of 44 per cent was cited. Berla merely mentions 12 cases of local recurrence. Johnson cites a recurrence rate of 39.4 per cent and Shallow 6 per cent.

NECESSITY FOR CLEAR EVALUATION

As one reviews the above reports, it becomes apparent that there exists marked variation, but of more important is the basis of estimation. Naturally, much confusion becomes manifest when effort is made to interpret and correlate such percentages. For instance, it is important to know the number of cases and whether all were resected. If so, were they resected for palliation or for cure, or for a combination of the two. If so, what was the percentage of each? Were the operative deaths included or excluded in the final estimation? Further, it should be

known whether the non-palliative cases included those "favorable" (no glandular involvement nor local extension), and the "less favorable" (with glandular involvement or local extension), and if so the percentage of each. Were estimates of recurrence calculated on recent cases or in a group over a five-year period? It is known that recurrence manifests itself most frequently during the first three years following operation and is uncommon although not a rarity after the fifth year. Gabriel and especially Webster have discussed this at length.

Another question, what is the ratio of recurrence and more specifically, what is the percentage of local recurrence? A few published reports are available from which one may attempt to correlate the contained data in an effort to arrive at a relatively accurate evaluation.

Lockhart-Mummery for example reported a group of 230 resections for rectal cancer, which were operated upon five years or more. One hundred died of recurrence so that the calculated recurrence rate is 43.4 per cent. Whether this is local recurrence is not stated; besides no mention is made of deaths from operation. Quite recently, Lynch and Hamilton analyzed 50 cases resected more than five years ago. Recurrence was noted in 16 instances, 12 of which showed the recurrence to be local. Lynch makes the statement that it is the rule for local recurrences to predominate in all types of operation for cancer at or about the rectosigmoid and in a previous article he mentions that a study of 500 of his patients operated upon by the combined method revealed that 70 per cent of the recurrences were local. In these 50 cases reported by Lynch and Hamilton there were five operative deaths so that by subtracting this fraction and dividing it into 16, the incidence of recurrence is estimated as 35.5 per cent, whereas the local recurrence rate (12 divided by 45) is 26.6 per cent.

Hayden in reporting 82 resections cites 27 instances of recurrence, which with the deletion of 11 operative deaths gives a figure of 38 per cent. The number of local recurrences is not stated.

Colcock recently reported a series of cases from the Lahey Clinic, in which, excluding those with liver metastasis, the combined groups of 73 patients (favorable) and 52 patients (unfavorable) totaled 125. If the 11 operative deaths are subtracted from the total, namely 125, the remainder 114, when divided into the number of recurrences 54, shows an incidence of recurrence of 47.3 per cent. The rate of local recurrence is not stated.

Wangensteen in evaluating the results achieved for carcinoma of the low pelvic colon and rectum, in which the sphincter muscles were preserved, observed a local recurrence rate of 14 per cent in the curative group, although all patients in the series had not been operated upon five years or more. The incidence of recurrence has been summarized in the accompanying chart:

INCIDENCE OF RECURRENCE

Author	Ref.	No. Resections	No. Oper. Deaths	Survival Rate 5 yrs. or More	Recurrence No. Cases Not Specified	Recurrence % Not Specified	Recurrence No. Cases Local	Recurrence % Local
Lockhart-Mummery	21	230 (5 yrs. or more)	?	52%	100	43.4	?	?
Lynch & Hamilton	22	50 (5 yrs. or more)	5	53.1%	16	35.5	12	26.6
Hayden	23	82	11	---	27	38	?	?
Colcock	24	125 (5 yrs. or more)	11	47.5%	54	47.3	?	?
David & Gilchrist	6	112 (5 yrs. or more)	12	51.8%	35	31.1	18	16
Johnson	17	38	7	36.8%	15	39.4	?	?
Where Sphincters Are Preserved								
Wangensteen (abdominal pull-thru)	25	63	---	---	---	---	7	14
Bacon & Vaughan (proctosigmoidectomy)	26	76 (5 yrs. or more)	5	52.6%	23	34.3	12	17.9

The advancements made in the field of colon surgery have been so marked in the last few years, that we now attempt resection in many cases that several years ago would have been labeled inoperable. This is due in part to a more thorough knowledge of the use of the chemotherapeutic and antibiotic agents, and in part to improved technique. The excellent work recently published by David and Gilchrist shows among other important facts that retrograde metastases to nodes one to five centimeters below the tumor occurred in only seven of the 153 tumors below the promontory of the sacrum 4.6 per cent). (The distance from the anal verge to the lower margin of the tumor in which retrograde metastases were found is not stated.)

Glover and Waugh concluded that retrograde metastases occurred only in those cases that were so far advanced that the normal lymph channels were blocked. They also offered evidence that only those cases that showed nodal involvement at least two centimeters or more distal to the mucosal edge of the tumor were

significant, since this is the distance to which the involvement commonly extends longitudinally in the bowel wall.

Author	Year	Total Cases	Positive Nodes Cases	Retrograde Nodal Involvement Cases	Distance Below Lesion - cm.
McVay	1922	100	47	1	0-1
Wood & Wilkie	1933	100	51	0	0
Westhues	1934	74	?	1	1
Gabriel, Dukes & Bussy	1934	100	62	2	0-1
Coller, Kay & MacIntyre	1940	33	22	1	1.5
Grinnell	1942	75	41	1	1
Glover & Waugh	1944	100	100		
				33	0-2
				1	2-3
				1	3-4
				1	6-7
Gilchrist and David	1947	153		3	1-2.5
				2	2.5-3.5
				2	3.5-5
				2	3.5-5
Total		735			

After reviewing the literature it is found that there are 735 cases reported in which the removed tissues were completely examined for nodal involvement. Of these cases there were 49 instances of nodal metastases 0 to 7 centimeters distal to the mucosal edge of the tumor mass. As stated, only those more than 2 centimeters distant are significant. Excluding those of 2 centimeters or less, there remain seven cases of nodal involvement between 2 and 7 centimeters distant, an instance of 0.95 per cent. In our group of 146 consecutive cases of patients with rectal cancer[6] serial sections made at 2, 4 and 6 centimeters below the lower margin of the growth disclosed but one instance where spread was evident at the 6 centimeter level,—an incidence of 0.68 per cent; and 2 at 2 centimeters below the growth, 1.3 per cent.

Glover and Waugh[3] postulate as follows: "Only one per cent of far advanced malignant growths of the pelvic colon may be expected to metastasize in a retrograde fashion. If this obtains so rarely in cases in which the patient is already doomed to an early demise because of the advanced nature of the lesion, one may be justified in making the statement that retrograde lymphatic metastasis never occurs from growths still in the stage of reasonable operability." From the figures herein presented one is forced to question the necessity of sphincter muscle removal in every instance.

SUMMARY

The incidence of recurrence and particularly local recurrence is cited following abdominoperineal proctosigmoidectomy where no colostomy is established and the sphincter musculature has been preserved. Effort has been made to evaluate this incidence in comparison with the published reports by other methods where the sphincters are sacrificed and an abdominal stoma is established. Attention is called to the difficulty of appraisal to determine the rate of recurrence in an effort to establish a standard method whereby statistical surveys may be made accurately.

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Endometrioma of the Umbilicus

Endometriosis of the umbilicus, although relatively rare, should be recognized easily if one is cognizant of the signs and symptoms. It is a condition appearing exclusively in women and is predominant in white females, with a single case being reported in a Negro. A review of the literature reveals that approximately 70 per cent of the cases start in the third decade of life. However, endometriosis may occur at either extreme of the menstruating age group. Enzer's case, a girl 18 years old, is the youngest on record, while the oldest reported occurred in a woman 57 years of age. Endometriomas of the umbilicus occur during the menstrual life, are small and slow growing, becoming swollen and discharging bloody fluid during the menstrual period in approximately 50 per cent of the cases. These symptoms are cyclic reappearing with the menses. However, the majority of the cases presented a normal menstrual history, although cases suggesting irregularity, attended with dysemenorrhea and profuse bleeding have been reported.

The presence of these tumors in association with an umbilical hernia is more than coincidental, as reported by Mintz, and Keitler and Lauche. In several cases in which the abdomen was opened, Goddard, Barker, Mahle and McCarty, Keitler. Kohler and Roques discovered that the findings were normal with no associated endometriosis of the uterus or other peritoneal structures. In contradistinction to these reports, Baltzer and Mintz found generalized endometriosis of the peritoneum, ovary, appendix and sigmoid. Fibromyomas, as well as ovarian tumors, were discovered in the following cases; Stacy, et al., and Kenne and Kimbrough. These varied and opposing findings are of considerable importance in speculating as to the causation of this entity.—O. J. Printz, J. H. Printz, S. Rubin; Jrn. of Mo. State Med. Assn., Vol. 46, No. 7, July, 1949.

Total Colectomy With Preservation of the Anal Sphincter

W. R. FUNDERBURG, M. D., C. W. CONSOLO, M. D., and R. E. SCHRINER, M. D.

THE operation of total colectomy is most often done for one of two conditions, multiple polyposis or severe chronic ulcerative colitis.

Lockhart-Mummery[1] noted that polyposis of the colon is a hereditary disease, transmitted by both males and females. The tendency can often be traced to several generations. While it has been known to make its appearance as early as two years[2] it is most often seen in the second and third decades. Such patients then eight to ten years later are very prone to develop cancer at some site in the rectum or colon. Various authors report an incidence of proved malignancy in such patients from as low as 26 per cent to as high as 62½ per cent. The usual figure is around 35 to 40 per cent.[3] Lockhart-Mummery goes so far as to state that all such patients will eventually develop malignancy if they survive.

The usual recommended procedure is resection of the involved bowel. This often means total colectomy with a permanent ileostomy. Another procedure recommended by some is fulguration of the rectum and lower sigmoid and then resection of the remainder of the colon with an ileosigmoidostomy. Adenocarcinoma has been reported to develop later in the remaining rectal segment.

The operation described in this case report is a total colectomy in which the ileum is sutured inside the anal sphincter and controlled by the same. The procedure follows very closely that used on dogs for total resection of the colon with preservation of the anal sphincter described by Rovitch, et al.[3] It is my understanding that the above author has, subsequent to this report, carried out this procedure on several patients with very gratifying results.

It will be noted that the history of this patient demonstrates very well the strong hereditary nature of this condition, having three members of his immediate family die at an early age from cancer of the bowel.

CASE REPORT

E. F., a 34-year-old, white male, was first admitted August 11, 1947, complaining of severe diarrhea with rectal bleeding for several weeks. The patient states that he was well until July 14, one month prior to admission, when he became suddenly ill while working, vomited and was taken home. He soon developed a diarrhea. The family physician was called. The patient's condition temporarily improved on the usual medication but the bowel habits never returned to normal. After a short time he developed some rectal bleeding and the diarrhea persisted. Patient was admitted to the hospital for diagnosis and treatment.

Submitted August 27, 1948.

The Authors

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Past History: The patient had the usual childhood diseases and scarlet fever at the age of 8. He had an umbilical hernia repaired in 1943. The previous history is otherwise normal except for anorexia and some weight loss for the past six months.

Family History: The mother died in 1931 at the age of 49 of cancer of the rectum. One brother died in 1939 at the age of 32 with cancer of the rectum. One sister died in 1930 at the age of 27 with cancer of the bowel. The patient has been married eleven years and has two living sons.

PHYSICAL EXAMINATION

Physical examination reveals a well-developed and poorly nourished white male, lying on his back complaining of no particular pain but of severe rectal bleeding. Skin is pale. His cooperation is good. I. Q. is normal. Head: The scalp is clean. The hair of normal texture. Eyes: The conjunctiva is not injected. The sclera is clear. Pupils are equal and regular. React to light and accommodation. No squint. The cornea is not abnormal. Ears: No discharge; Ext. aud. meatus normal; the drums are clean and glistening. Nose: Mucosa normal color; no septal perforation or deviation, or deformity; no discharge; no tumors. Mouth: Buccal M. M. normal color; the tongue is not coated; no fissures; no tremor; the tongue does not deviate. Pharyngeal mucosa is not injected. Neck: There are no visible tumors or pulsations; no rigidity; no lymphadenopathy. Trachea is in the mid line. Chest: Expansions are equal and regular. The lung fields are clear. Heart: Normal size; no excessive precordial activity; heart sounds are clear; no murmurs. Blood pressure 130/70; rate 79; rhythm regular and no pulse deficit. Abdomen: There are no tumors or pulsations; transverse scar at the level of the umbilicus. Liver, spleen, and kidneys are not palpable; marked tenderness over the lower abdomen; no definite localization. Genitalia: Normal male. Rectal: Definite hemorrhoids and rectal tabs; bright red rectal bleeding. Extremities: Nor-

mal; no missing members. Reflexes are equal and regular.

X-ray examination of the chest was negative. X-ray following barium enema is diagnostic of diffuse polyposis of the colon.

Laboratory findings: Urine is negative for sugar and albumin. Specific gravity is 1010; acid in reaction; microscopic examination normal. White blood count 8,500. Red blood count 3,530,000; 64 per cent hemoglobin.

Operation at this time consisted of removal of several polypus on sigmoidscopic examination and three blood transfusions during his hospital stay.

Pathological report: Microscopic diagnosis of the polyps submitted to pathological examination: "Polyposis of the sigmoid. The cells of the polyp are large and slightly irregular, however, the basel membranes are not broken and the base is not invaded. Nevertheless, the patient should be kept under close observation since premalignant changes are present in the cells." However, after verbal discussion with Dr. von Haam concerning this case, and considering his family history, it was decided that a total colectomy should be done for the patient's safety. The patient was re-admitted to the hospital September 28, 1948.

Interval Note: The patient continued to lose blood per rectum with every bowel movement. The patient was given three transfusions and daily injection of 5 cc. of B complex and 100 milligrams of vitamin C intravenously in preparation for surgery. The operation was performed on October 11, 1948.

OPERATION

Total colectomy with Preservation of the Anal Sphincter: Under 15 milligrams of pontocaine anesthesia the patient was prepared and draped in the usual manner. A low mid-line incision was made. The peritoneum was opened and the small bowel was packed away. The cecum was pulled medially and an incision was made in the peritoneal reflection close to the lateral wall of the bowel from the tip of the cecum to the region of the hepatic flexure. The hepatocolic ligament with its blood vessels were divided and ligated. The bowel was then pulled further mesially, the loose areolar tissue underlying it was pushed down with moist gauze sponge. The ureter was identified and dissected free from the peritoneal reflection. The mesentery over this area was then divided, ligating the right colic and ilio-colic arteries. The mesentery of the terminal ileum, was then divided for a distance of approximately 3 inches, ligating all vessels. The precedure was then carried around to free the transverse colon, clamping and ligating the transverse meso-colon with special ligature on the middle colic artery. The pack was then removed, the small bowel repacked to the right side of the abdominal cavity. The left colon was then pulled medially and the lateral reflection of the peritoneum was incised close to the bowel for free mobilization.

Following this the bowel was retracted in the midline, the mesentery dissected from the posterior abdominal wall by the use of gauze on the index finger. The mesentery was then clamped, divided, and ligated. The incision in the lateral peritoneum was then extended into the pelvis around, anterior to the rectum, at the most dependent level of the cul-de-sac. The left ureter was visualized and avoided. The sigmoid was then reflected to the left side and the peritoneum incised in a similar fashion on the right side until the incision connected with that on the left. Clamps were applied on the mesentery which was divided, the vessels were ligated. The superior hemorrhoidal artery was divided at the level of the bification of the aorta. The rectum was then freed anteriorly from the prostate and posteriorly from the hollow of the sacrum as far as the tip of the coccyx. The suspensory ligaments of the rectum were clamped, divided without ligature, and when the dissection had been carried as low as the tip of the coccyx, the entire bowel was then packed in layers in the pelvis and the peritoneum was closed. The rectus sheath was closed with nylon 0 and the skin with clips. Patient was then placed in lithotomy position. The anus and the lower rectum was packed with dry gauze to support the mucosa in the dissection. The anal margin was held with Allis clamps and a circular incision was made in the mucocutaneous junction. Dissection was carried up submucosally for a distance of 8 to 10 cms. The dissection was then carried through the outer rectal coats into the peritoneal cavity. The freed bowel was then pulled through the intact sphincter. The entire colon and mobilized part of the ileum were delivered. The peritoneal cavity was then sealed off with a continuous chromic suture operating through the dilated sphincter. The levator ani muscles were pulled together beneath the ileum for added pelvic support and sutured with chromic 0. No attempt was made to suture the ileum to the anus. The ileum was ligated leaving approximately 4 cms. of the ileum protruding. A large rectal catheter was then tied into this protruding ileum to prevent early contamination. A Fulley catheter, which had been previously installed in the bladder, was left in place.

PATHOLOGICAL REPORT

Gross Description: The specimen (Figure 1) consists of an extirpated colon measuring 27 inches in length. It includes the cecum and the appendix. The mucosa of the colon is studded with innumerable small polypoid masses, some of which possess long pedicles while others have a stubby wartlike appearance. The polyposis involves the cecum, ascending, transverse and descending colon. The lower sigmoid is filled with polyps and is markedly distended. The mucosa appears atrophic and smooth.



Figure 1. Picture of a portion of the resected colon. This is representative of the entire colon.

Microscopic Diagnosis: Numerous sections were

studded. Many of the polyps were definitely benign with long pedicles and no evidence of atypical epithelium. Others were of the precancerous type with irregular epithelium and infiltration of the base. In a few the picture of anaplasia had advanced to that of adenocarcinoma with definite invasion of the base. Diagnosis: Polyposis of the colon with precancerous and early carcinomatous changes.

The patient's postoperative course was uneventful. He ran a temperature of 100 to 101 for several days. There was very little abdominal distention. Clips were removed on the sixth day, the wound was well healed. The redundant portion of the ileum was removed flush with the anus on the eighth day with a tonsil snare. By the end of three weeks the patient was definitely conscious of the defecating impulse. By the fifth week he could hold his stool for a bed pan. By the time of the patient's discharge he could hold a solid or semi-solid stool indefinitely but was still having incomplete control when he had diarrhea. By the time of the final examination on July 1, 1948, the patient had been working for four months full time, had gained 20 lbs. and had excellent control of bowel movements. There had been some tendency for the anus to constrict, it had been kept dilated without too much difficulty with finger dilatation. As long as he stays on a modified chronic colitis diet he has no diarrhea.

CONCLUSIONS

A case of polyposis of the colon is presented which illustrates the following things, the strong hereditary nature of this condition, the tendency of this chronic condition to undergo early malignant change, and an operative procedure which totally removes the colon and rectum but leaves the patient with a functional anus.

ADDENDUM

Additional Case. On September 30, 1948, an identical procedure was carried out on this patient's 33-year-old sister. The pathological diagnosis was generalized polyposis of the entire colon. The polyps were definitely premalignant in character.

The patient's recovery was uneventful and she is already developing moderate control of her perineal iliostomy.

This is the last member to be operated of the family of five, a mother and four children. To review, the mother and two older children died with carcinoma of the large bowel before they were 40. The two cases here submitted are the two younger children. This demonstrates the strong hereditary nature of this disease.

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The Story Behind the Word: Some Interesting Origins of Medical Terms

Quarantine:—Literally means forty days and the word is derived from the Italian word "quaranta," meaning forty. Its present-day meaning dates from the middle ages when Venice and the Honseatic Cities detained arriving ships with cases of pestilence aboard for the Biblical period of forty days.

Vitamin:—This word was coined in 1911 by Casimer Funk, a Polish physiologist. He believed that chemically these substances were amines necessary to life and hence called them "Vital Amines."

Morphine:—This drug is named after Morpheus, the prime minister to Somnus, the God of Sleep. In the classical mythology Morpheus is pictured as an aged man with wings pouring a vaporous narcotic from a horn.

X-Rays:—X-rays were discovered in 1895 by Wilhelm Konrad Roentgen, a German professor of physics at the University of Wurzburg. Roentgen refused to give his own name to the rays, stating that he preferred to call them X-rays because he did not understand their nature and X represented the well-known Algebraic symbol of the unknown.

Phalanges:—The small bones of the fingers and toes were named phalanges from their fancied resemblance to the Greek line of battle formation called a phalanx.

Temporal Bones:—These are named from the Latin word "tempus" or time, because it is on the temples that the hair first becomes gray thus showing the ravages of time.

Fontanels:—The fontanels are so named from the pulsations which can be seen in some of them and which the early anatomists likened to the rise and fall of water in a fountain.

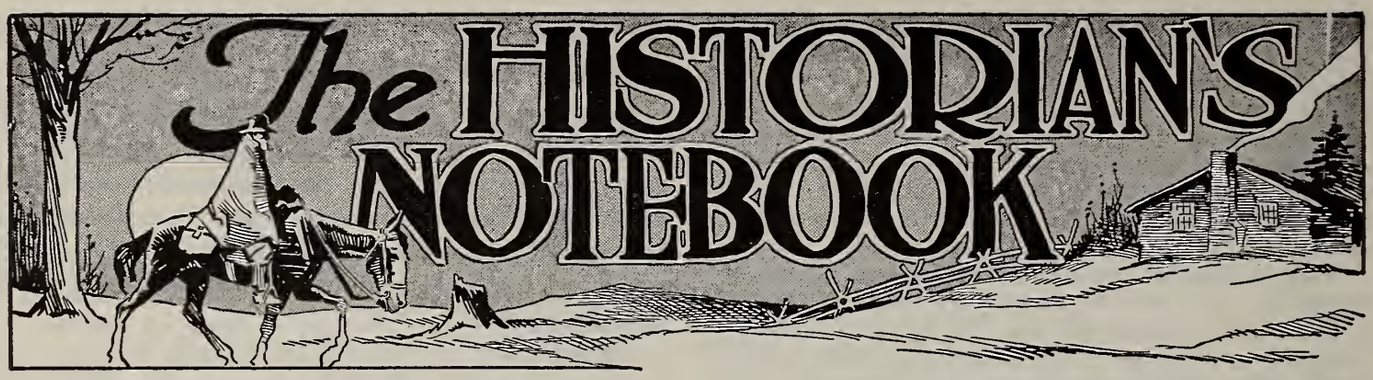
Os-Innominatum:—The innominate bone or os-innominatum literally means the "unnamed bone." This name was given to it because it did not resemble any known object.

Coccyx:—These four rudimentary bones of the spinal column derive their name from the Greek word for cuckoo and are so called from their fancied resemblance to the Cuckoo's beak or bill.

Tularemia:—This disease is so named from first being described as occurring in Tulare County, California. McCoy of the United States Public Health Service described the disease in 1911 as "a plague like disease of rodents" in the ground squirrels of Tulare County, California. Francis in 1919 named the disease Tularemia.

Chalazion:—This little tumor at the edge of the eyelid is so called from its fancied resemblance to a hailstone. The term is derived from the Greek word "Chalaza" or hail.

—Harry Wain, M. D., Mansfield, Ohio.



A Popular Conception of Asthma in 1838

JONATHAN FORMAN, M. D.

WE ARE reproducing here the chapter on asthma in the twenty-second English edition of William Buchan's *Domestic Medicine* as adapted for the Diseases of the United States by J. G. Norwood, M. D., and published by U. P. James in Cincinnati, Ohio, in the year 1838.

One of the earlier of the home remedy medicine books was this one which first appeared in Edinburgh in 1769. It went through many editions in many lands. Competent historians have said that the influence of this book was greater than any similar work ever published. The book was intended to supplement the physician and to render Medicine more universally useful by extending its benefits. Buchan's information on preventive medicine is extraordinarily modern.

For those who think our present concept of asthma and what to do for it sprang full grown from the observations on the anaphylactic guinea pigs should read the following.

* * *

ASTHMA—PHTHISIC

The asthma is a spasmodic* disease of the lungs, coming on by paroxysms, which seldom admits of a cure. Persons in the decline of life are most liable to it. It is distinguished into the moist and dry, or humoral and nervous. The former is attended with expectoration or spitting; but in the latter the patient seldom spits unless sometimes a little tough phlegm, by the mere force of coughing.

It rarely appears before the age of puberty, and seems to attack men more frequently than women; particularly those of a full habit, in whom it seldom fails, by frequent repetition, to occasion some degree of emaciation. When the disease is attended with an accumulation and discharge of humors from the lungs, it is called the humid asthma; but when it is unaccompanied by any expectoration, it is known by the name of the dry or spasmodic asthma.

CASES

The asthma is sometimes hereditary. It may likewise proceed from a bad formation of the breast; the fumes of metals or minerals taken into the lungs; violent exercise, especially running; the obstruction of customary evacuations; sudden retrocession of the gout, or striking-in of eruptions; and violent passions of the mind. In a word, the disease may proceed from any cause that either impedes the circulation of the

* Dr. Cullen, and most other writers, refer the proximate or immediate cause of asthma to a preternatural or spasmodic constriction of the muscular fibres of the air-cells of the lungs, which not only prevents their being so dilated as to admit of a free and full inspiration, but also gives them a rigidity which interferes with a free and full expiration. This doctrine, however, has been disputed by Dr. Bree, who, in a very ingenious treatise on this disease, gives it as his opinion that irritation situated within the bronchia or air-cavities, and arising either from an effusion of serum, or from aerial acrimony, is the true proximate cause of convulsive asthma. The mucus, which is excreted in the course of the disease, and which has been looked upon by Dr. Cullen and others as only an effect, Dr. B. views as a prominent cause of the paroxysm; or when it is absent, only yielding to a different cause equally irritating to the organ, and exciting spasmodic contractions of the respiratory muscles. Dr. Darwin says that whatever may be the remote causes of paroxysms of asthma, the immediate cause of the convulsive respiration, whether in the common asthma, or in what is termed the convulsive, which are perhaps only different degrees of the same disease, must be owing to violent voluntary exertions to relieve pain, as in other convulsions; and the increase of irritability to external stimuli, or of sensibility during sleep, must occasion them to commence at this time.

The Author

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blood through the lungs, or prevents their being duly expanded by the air.

SYMPTOMS

Asthma is known by a quick laborious breathing, which is generally performed with a kind of wheezing noise. Sometimes the difficulty of breathing is so great, that the patient is obliged to keep in an erect posture, otherwise he is in danger of being suffocated. A fit or paroxysm of the asthma generally happens after a person has been exposed to cold easterly winds, or has been abroad in thick foggy weather, or has got wet, or continued long in a damp place under ground, or has taken food which the stomach could not digest.

The paroxysm is commonly ushered-in with a listlessness, want of sleep, hoarseness, a cough, belching of wind, a sense of heaviness about the breast, and difficulty of breathing. To these succeed heat, fever, pain of the head, sickness and nausea, great oppression of the breast, palpitation of the heart, a weak and sometimes intermitting pulse, an involuntary flow of tears, bilious vomiting, etc. All these symptoms grow worse towards night; the patient is easier when up than in bed, and is very desirous of cool air.

After some nights passed away in this manner, the fits at length moderate, and suffer more considerable remissions, particularly when they are attended by a copious expectoration in the mornings, and when this continues from time to time, throughout the day; and, the disease going off at last, the patient enjoys his usual rest by night without further disturbance. The pulse, during the fit, is usually not much affected, but in a few cases there is a frequency of it, with some degree of thirst and other febrile symptoms.

REGIMEN

The food ought to be light and of easy digestion. Boiled meats are to be preferred to roasted, and the flesh of young animals to that of old. All windy food, and whatever is apt to swell in the stomach, is to be avoided. Light puddings, white broths, and ripe fruits baked, boiled or roasted, are proper. Strong liquors of all kinds, especially malt liquor, are hurtful. The patient should eat a very light supper, or rather none at all, and should never suffer himself to be long costive. His clothing should be warm, especially in the winter season. As all disorders of the breast are much relieved by keeping the feet warm, and promoting perspiration, a flannel shirt or waistcoat, and thick shoes, will be of singular service.

But nothing is of so great importance in the asthma as pure and moderately warm air. Asthmatic people can seldom bear either the close heavy air of a large town, or the sharp keen atmosphere of a bleak hilly country; a medium, therefore, between these is to be chosen. The air near a large town is often better than at a distance, provided the patient be removed so far as not to be affected by the smoke. Some asthmatic patients indeed breathe easier in town than in the country; but this is seldom the case, especially in towns where much coal is burnt. Asthmatic persons who are obliged to be in town all day, ought at least to sleep out of it. Even this will often prove of great service. Those who can afford it ought to travel into a warmer climate. Many asthmatic persons who cannot live in Britain, enjoy very good health in the south of France, Portugal, Spain, or Italy.

Exercise is likewise of very good importance in the asthma. The blood of asthmatic persons is seldom duly prepared, owing to the proper action of the lungs being impeded. For this reason such people ought daily to take as much exercise, either on foot, horesback, or in a carriage, as they can bear.

TREATMENT

Almost all that can be done by medicine in this disease, is to relieve the patient when seized with a violent fit. This indeed requires the greatest expedition, as the disease often proves suddenly fatal. During the paroxysm the body is generally bound, a purging clyster, with a solution of assafoetida, ought therefore to be administered, and if there be occasion, it may be repeated two or three times. The patient's feet and legs ought to be immersed in warm water, and afterwards rubbed with a warm hand, or dry cloth. Bleeding, unless extreme weakness or old age should forbid it, is highly proper. If there be a violent spasm about the breast or stomach, warm fomentations or bladders filled with warm milk and water, may be applied to the part affected, and warm cataplasms to the soles of the feet. The patient must drink freely of diluting liquors, and may take a tea-spoonful of the tincture of castor and saffron mixed together in a cup of valerian-tea, twice or thrice a day. Sometimes a vomit has a good effect, and snatches the patient, as it were, from the jaws of death. This, however, will be more safe after other evacuations have been premised. A very strong infusion of roasted coffee is said to give ease in an asthmatic paroxysm.

In the moist asthma, such things as promote expectoration or spitting, ought to be used; as the syrup of squills,* gum-ammoniac, and such

*Take Mixture of Ammoniacum, 4 ounces.
Oxymel of Squills, 3 drachms.
Solution of Antimony Wine, 40 drops.
Distilled Vinegar, ½ ounce.
Make a mixture; of which two table-spoonfuls are to be taken often, or when either the cough or shortness of breath is troublesome. *Or*
Take Mixture of Ammoniacum 1 ounce.
Solution of Acetated Ammonia, 2 drachms.
————Tartarized Antimony, 15 drops.
Syrup of Tolu, 1 drachm.
Make a draught, to be taken every six hours.

like. A common spoonful of the syrup or oxymel of squills, mixed with an equal quantity of cinnamon-water, may be taken three or four times through the day, and four or five pills made of equal parts of assafoetida and gum-ammoniac at bed-time.†

A combination of foxglove and opium has proved highly advantageous in spasmodic asthma, when given in the dose of half a grain of each every four or five hours. In the pituitous asthma, squill and foxglove might be more advisable.‡

On the authority of a modern writer, galvanism was found most efficacious in relieving habitual asthma.

For the convulsive or nervous asthma, antispasmodics and tonics are the most proper medicines. The patient may take a teaspoonful of the paregoric elixir twice a-day. Bitter infusions, chalybeate waters, and preparations of iron, particularly the subcarbonate and sulphate, in short, every thing that braces the nerves or takes off spasm, may be of use in a nervous asthma.

[The smoking of the leaves and root of the Jamestown-weed *(datura stramonium)* is strongly recommended as an expectorant and antispasmodic in this disease. The skunk cabbage is also highly extolled by many who have given it a trial. The dose of the dried root, in powder, is from thirty to forty grains, repeated as often as circumstances may require. "Of all the remedies we possess, however, the *lobelia inflata* is, I think, decidedly the most beneficial in this affection." (Eberle.) A table-spoonful of the saturated tincture may be given every ten or fifteen minutes.]

In addition to other tonics, exercise either in swinging, sailing, riding in a carriage, or on horseback, but particularly the latter, together with a change of air, will be beneficial to asthmatics: They should try different situations to live in, where the disease is rendered less distressing, or is entirely removed. Their clothing should be warm.

In the arthritic asthma, arising from the retrocession of gout, there are usually intermissions and other irregularities of the pulse, great anxiety of countenance, with a bluish tinge thereon. Large doses of opium, ether, camphor, and ammonia are the medicines most likely to afford relief. Sometimes it is necessary to bleed the patient, and often to apply a blister to the chest.

In every species of asthma setons and issues have a good effect they may either be set in the back or side, and should never be allowed to dry up. We shall here, once for all, observe, that not only in the asthma, but in most chronic diseases, issues are extremely proper. They are both a safe and efficacious remedy; and though they do not always cure the disease, yet they will often prolong the patient's life.

This disease, though so common with us, is little known in mild climates; and, on that account, it is always advisable to try the effect of a change of climate, which has generally been attended with great benefit. I have already intimated what little confidence I had in the power of any medicine to perform a radical cure of the asthma; but there are many things that will give the patient ease, and, of course, tend to prolong his life. Much, also, may be done by regimen, when drugs are of little service; and I would therefore advise asthmatic patients to procure and keep by them rules for their management both in and out of the fit, adapted to their particular cases. By a proper attention to such rules a man may live many years, and enjoy tolerably good health.

I had a patient some time ago, who was often carried home to his wife in an apparently dying state. She felt little alarm, well knowing what was necessary to be done; and she always brought him about. This good woman did no more than may be done by any woman of common sense, if the doctor will deign to instruct her. General rules will not do; they must, as before observed, be suited to the patient's case and constitution. For want of some such instructions, which a physician should take the earliest opportunity to give, a patient may lose his life before the doctor can be sent for, or any other medical advice or assistance procured.*

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† After copious evacuations, large doses of ether have been found very efficacious in removing a fit of the asthma. I have likewise known the following mixture produce very happy effects: To four or five ounces of the solution or milk of gum ammoniac, add two ounces of simple cinnamon water, the same quantity of balsamic syrup, and half an ounce of paregoric elixir. Of this two tablespoonfuls may be taken every three hours.

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‡ Take Foxglove in powder 6 grains
Compound Squill Pill, 2 scruples
Syrup of Tolu, enough to make the mass into 12 pills, one to be taken three or four times a-day.

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* Asthma is a disease more immediately alarming in appearance, than dangerous in reality. It is well to be aware that there is hardly an instance known of a person dying during the asthmatic paroxysm. The duration of life seems even rarely to be shortened by this complaint. The celebrated Dr. Floyer, who wrote on asthma, although he labored under that disease during his whole life, died upwards of eighty years of age. He was of opinion that he shortened and lightened his fits by drinking some cups of very strong coffee without tea or sugar. I have known more than one asthmatic, who never lay down in bed for a long series of years, and notwithstanding, during the intervals of the fits, enjoyed tolerable health. Much depends on adhering to a dry diet, taking regular exercise, and on abstaining from those things which are known, by the individual experience, to disorder the stomach. Considerable benefit is derived, in the nervous asthma, from occasionally taking as much genuine assafoetida, made into pills, as is sufficient to keep the body regular. Smoking the herb stramonium, shortens the duration of a fit, but does not permanently cure the disease, nor even diminish the number of paroxysms. See *New Domestic Medical Manual*, by J. S. Forsyth.

Review of Ohio Legislature . . .

Hectic Regular Session Ends on July 15; Digest of Health, Medical and Welfare Measures; Action Taken by General Assembly on Each

FINAL working session of Ohio's Ninety-Eighth General Assembly was held on July 15, bringing to a close one of the most hectic regular sessions ever held by Ohio's legislative body.

Scores of radical measures of all kinds were tossed into the hoppers and were pushed vigorously by various radical groups. Nevertheless, the conservative membership prevailed in the final analysis, and no really vicious proposal was enacted.

A number of bills which would have broken down the public health laws and medical practice act were defeated despite the fact that they had the support of a surprisingly large number of members during their hearing stages. This meant much additional work for the representatives of the medical profession and health organizations in Columbus and "back home." The good work of legislative chairmen in certain key counties is largely responsible for the killing of some of the radical anti-health and anti-medical measures in committee.

LEADERS COOPERATIVE

Although they had had no previous experience as chairmen of the Senate and House health committees, respectively, Senator Catherine R. Dobbs, Barberton, and Representative Lee D. Kepner, Warren, made excellent records in directing the activities of these two important committees, permitting representatives of the medical profession unlimited time for the presentation of arguments and information for or against the many bills which their committees handled.

The leaders of both parties in the Senate and House were exceedingly cooperative on questions discussed with them by representatives of the State Medical Association. These included: Senator Margaret A. Mahoney, Cleveland, president pro tem and Democratic floor leader of the Senate; Senator Roscoe R. Walcutt, Columbus, the Republican floor leader in the Senate; Speaker John F. Cantwell, Youngstown, of the House; Representative A. G. Lancione, Bellaire, speaker pro-tem and Democratic floor leader; and Representative C. William O'Neill, Marietta, House Republican floor leader.

DIGEST OF IMPORTANT HEALTH BILLS

Following is a digest of bills which had a medical-health-welfare angle, and a few of general importance, with the action taken on them indicated:

Senate Bill 26, to increase the fee for obtaining from the Ohio Department of Health a certified copy of a birth certificate, from 25 cents to 50 cents. **Enacted.**

Senate Bill 63, to reduce to 55 per cent the majority necessary to pass special tax levies for health, welfare and relief purposes. **Enacted.**

Senate Bill 50, revision of the educational sections of the State Optometry Practice Act. **Enacted.**

Senate Bill 60, stream pollution control act. **Enacted.**

Senate Bill 42, to establish a commission to study the tax and revenue problems of the state. **Enacted.**

Senate Bill 95 to establish a state board to examine and license practical nurses. Passed Senate. **Killed by House Health Committee.**

Senate Bill 126, to provide that anyone holding a certificate to practice medicine or any of its branches must indicate the degree he holds on letterheads, signs, etc. **Died in Senate Health Committee.**

Senate Bill 133, to establish a separate board to examine and license naturopaths. **Killed by Senate Health Committee.** Same as **House Bill 613** which died in House Health Committee.

TO STUDY DISABILITY INSURANCE

Senate Bill 134, creates a commission to study disability unemployment insurance. **Enacted.**

Senate Bill 151, to eliminate most of the present laws regarding privileged communications as they relate to physicians. **Died in Senate Judiciary Committee.**

Senate Bill 178, increases the fee for state inspection of plumbing. **Enacted.**

Senate Bill 188, to permit Division of Aid for the Aged to make lump-sum payments to hospitals, for out-patient services to recipients of aid for the aged. **Enacted.**

Senate Bill 196, permits payment of up to $10.00 per diem to hospitals for services rendered persons injured in motor vehicle accidents who cannot pay for such hospital services. **Enacted.**

Senate Bill 198, to permit the creation of regional sewer and water agency by political subdivisions to control sewage, surface waters and industrial waste. **Enacted.**

NEW DRUGS COVERED

Senate Bill 222, places new synthetic drugs—isonipecaine (demerol), amidone (methadon, dolophine, adanon), isoamidone, and ketobemidone—under the Ohio Narcotic Control Act, making them subject to the same provisions as

to manufacture and distribution as other narcotic drugs. **Enacted.**

Senate Bill 224, to establish a narcotic drug enforcement division in the Office of the Attorney General. **Died in Senate Judiciary Committee.**

Senate Bill 259, to establish a civil defense section in the Office of the Adjutant General to function in time of state or national emergency. **Enacted.**

Senate Bill 372, to tighten up the control of Bang's disease in cattle. **Enacted.**

Senate Bill 395, to authorize counties to issue bonds for emergency poor relief. **Enacted.**

Senate Bill 412, emergency appropriation of $2,000,000 to permit the state to match poor relief expenditures by the local relief areas. **Enacted.**

Senate Bill 23, providing for registration of marriages and divorces in the Ohio Department of Health. **Enacted.**

RESTAURANT INSPECTION BILL FAILS

House Bill 44, to transfer sanitary inspection of restaurants from State Fire Marshal's Office to Ohio Department of Health. **Defeated by House.**

House Bill 75, to require the enrichment of flour and bread with vitamins. **Enacted.**

House Bill 95, enabling legislation to provide for the direction and operation of the new tuberculosis hospital at the Ohio State University Medical Center by the Ohio Department of Health. **Enacted.**

House Bill 99, to create a registry in the Ohio Department of Health for public health sanitarians. Passed by House. **Died on Senate calendar.**

SLUM CLEARANCE ENACTED

House Bill 195, rehabilitation and redevelopment of slum areas. **Enacted.**

House Bill 205, appropriation of approximately $4,500,000 for capital improvements at various hospitals under control of Ohio Department of Public Welfare. **Enacted.**

House Bill 223, to authorize county commissioners to pay for medical, dental, hospital and optometrical services for those on blind relief, up to $200 in any one year. **Enacted.**

House Bill 277, recodification of state poor relief laws. **Enacted.**

House Bill 293, to exempt Christian Science practitioners from provisions of the Medical Practice Act. **Enacted,** making Ohio the 48th state to enact such an exemption.

House Bill 304, to establish a separate examining and licensing board for chiropractors. **Died in House Health Committee.** Similar bill died in Senate Judiciary Committee.

BARBITURATE CONTROL ACT

House Bill 308, to regulate the sale and distribution of barbiturates. **Enacted. Effective August 12. See July issue of The Journal for digest of this new law.**

House Bill 345, to create a state recreation commission to assist in the development of local recreation programs. **Defeated in the House.**

House Bill 382, general readjustment of salaries and wages of various state employees and reclassification of state employees, effective in 1951. **Enacted.**

House Bill 444, penalty for professional advertising when unlicensed in that profession. **Died on House calendar.**

House Bill 446, commission to study chronic alcoholism. **Enacted.**

PRACTICAL NURSE BILL DIES

House Bill 462, state board to regulate practical nurses. Different from Senate Bill 95. **Died in House Health Committee which also killed Senate Bill 95.**

House Bill 470, to permit collection of more than ceiling of $5.50 per day for the support of patients in various state mental institutions. **Enacted.**

House Bill 493, simplifying procedure for commitment of persons to state institutions for observation. **Enacted. Effective September 25.**

House Bill 531, increase of benefits of the Workmen's Compensation Act. **Enacted.**

House Bill 556, authority for coroner to dispose of firearms seized by him. **Enacted.**

House Bill 557, penalty for not answering a coroner's summons. **Enacted.**

House Bill 564, to create commission to revise and recodify the laws relating to the Ohio Department of Health. **No action by House Health Committee.**

House Bill 613, to create a separate board to examine and license naturopaths. **Killed by House Health Committee.**

APPROPRIATIONS BILLS

House Bill 654, general appropriations bill. **Enacted.** Ohio Department of Health granted an increase of approximately $80,000 each year of the biennium. Total appropriation approximately $647,000,000 for the biennium.

House Bill 655, appropriates approximately $90,000,000 from state surplus for capital improvements. **Enacted.** Appropriates $1,500,000 for additions to Hamilton Hall, Ohio State University Medical Center, and equipment for new buildings of Medical Center now under construction. Appropriates $600,000 for equipment at Tuberculosis Hospital, Ohio State University Medical Center. Appropriates $100,000 to Ohio Department of Health for cancer research project, Ohio State University.

Educational Program Clicking . . .

House of Delegates of A. M. A. Gives Whitaker and Baxter Go Ahead Signal as Campaign To Tell Medicine's Story Gets Into Full Swing

OHIO physicians are furnished a cue to the extent of the educational program being carried on by the American Medical Association in a report approved by the House of Delegates at the recent Atlantic City session.

One of the most encouraging points of the report is the revelation that more than a thousand organizations, many of them national in scope, have taken their places beside organized medicine against compulsory health insurance.

The willingness of doctors to do their part by passing out educational literature to their patients and others is another encouraging point in the report. After the notice about the poster "The Doctor" was sent out, 40,000 orders for copies were received in a five weeks' period. At the time of the report, orders were still coming in at the rate of 1,000 a week.

Orders for more than a half million pieces of literature have come through the Columbus headquarters office of the Ohio State Medical Association alone and have been filled.

The report approved by the House of Delegates includes a vote of complete confidence in the public relations team headed by Whitaker and Baxter which is working under the direction of a committee composed of A. M. A. officials.

TEXT OF REPORT

The text of the report is as follows:

Report of Coordinating Committee: The Coordinating Committee, immediately after organizing, decided to employ Whitaker and Baxter as campaign managers. They were employed not only because of their general reputation, but because they were familiar with our problem. They have established offices at 1 North LaSalle Street, Chicago.

The committee then decided to organize a Committee of 53, representing each state and territorial medical association.

Whitaker and Baxter now report that over one thousand organizations are on record against compulsory health insurance. These organizations include:

The American Federation of Women's Clubs
The American Bar Association
The American Farm Bureau
The National Fraternal Congress of America, including over 200 Lodges
Two of the Small Business Organizations
The National Catholic Welfare Conference
The National Conference of Catholic Charities
The Catholic Hospital Association
The American Protestant Hospital Association
The American Legion, and many others.

Twenty-five million pieces of literature have been mailed out. It is important that the states see to it that this literature actually reaches the people.

Two million five hundred thousand pieces of literature have been mailed direct from Whitaker and Baxter, and not to state associations.

For the information of our members, let it be known that there is no limit to the amount of material which will be mailed to any state association or individual so long as it can be used effectively. Besides state associations and individual physicians, all endorsing organizations receive the literature.

TYPICAL WEEK

To give an example of a typical week in Whitaker and Baxter's office, the following represents the organizations contacted in that period of time:

12,000	Trade associations
2,700	Chambers of commerce
500	Prominent clubs with civic influence
120	Advertising clubs
1,500	Kiwanis clubs
4,500	Lion's clubs
2,300	Rotary clubs
1,300	Carnegie libraries
900	College libraries
8,000	Public libraries
14,000	School principals and superintendents
9,000	Y. M. C. A. city associations
200	Y. W. C. A. city associations
130,000	Dentists and druggists

After the notice about the poster, "The Doctor," was sent out, 40,000 orders were received in five weeks, and the orders are now coming in at the rate of 1,000 a week. A wide distribution of this poster is essential.

One hundred and sixty-three thousand doctors are now on the mailing list. A letter goes to each doctor not less often than once in two months. It is intended that each doctor on the list will receive a limited supply of all literature hereafter published, with an order card so that he may order what he desires.

The voluntary medical care plans have been assisted by the preparation and distribution of literature.

In order to take the financial load off the states, Whitaker and Baxter will make original

mailings direct to doctors of 50 copies of each pamphlet, except where every doctor has been supplied from his own state.

A letter has been sent to each member of Congress explaining the program of the American Medical Association and enclosing a blueprint of the campaign.

Seventy-six hundred interns are on the mailing list and receive the same literature as practicing physicians.

Whitaker and Baxter report that 500 drug stores in Oklahoma will use the picture "The Doctor" as their main window display during one week.

Monroe County, New York, reports that through the "Tell 20 Plan" 15,000 letters were sent to the President and Congress in one week.

One hospital in Denver, Colo., is getting from 150 to 160 signatures a day to a letter prepared by the hospital, to be sent by friends and relatives of patients in the hospital.

FULL COOPERATION ESSENTIAL

Whitaker and Baxter report that one third of the states are doing an excellent job in the campaign; one third are doing a fair job, and one third are doing a poor job. It is important that all states do an excellent job. The states not doing a good job are not always the poorly organized states. One state with no full time office has turned in a tremendous record.

The Woman's Auxiliary has been of tremendous assistance in the campaign and great credit is due this organization. State and county associations should give their auxiliaries explicit directions and make use of them. They are not only willing but anxious to help.

With reference to the resolution introduced by the New York delegation and referred by the House to the Board of Trustees, the House will be interested to know that some of the actions desired have been anticipated.

Ten million envelope and stationery stickers have been printed. These stickers read as follows:

As Your Personal Physician

I Oppose Compulsory Health Insurance because—

It would bring you inferior medical care at high cost—

Invade your medical privacy—Put both of us under political control.

If you agree, please write your U. S. Senators and Representatives.

For more information, ask me.

When these are reprinted, there is no objection to printing them in the form of the poster, but it should be remembered that reduction of the picture, to the size of a stamp, plus the words "Keep Politics Out of This Picture," may make the picture too small to be decipherable.

Mats for newspapers have already been prepared and are available.

Literature for the drug stores has already been distributed. It has been offered to 55,256 stores. Through the state and county societies they should be offered the poster.

Literature has also been sent to 83,335 dentists.

The campaign is in full swing and will be kept there. A great deal has been accomplished, but more activity is necessary and will be carried on.

The Coordinating Committee at its last meeting passed unanimously a vote of full confidence in Whitaker and Baxter.

Two Doctors on Commission To Study Youth Problems

Dr. James G. Kramer of Akron and Dr. Thomas E. Shaffer of Columbus, both active in Ohio State Medical Association committee work, have been named by Governor Lausche on the Ohio Commission on Children and Youth.

The 17-member commission is to study the state's juvenile problems in preparation for a White House Conference, which is called every ten years by the President. Judge Raymond P. Smith of Lima has been appointed chairman. Mr. J. Gordon Crowe of Columbus has been named by the commission as executive secretary.

Dr. Kramer is chairman of the Association's Committee on Public Relations and Economics. Dr. Shaffer is chairman of the Committee on School Health and is chairman of the Section on Pediatrics.

American Heart Association Announces New Grants

Eleven research grants approximating $50,000 for investigation of heart and circulatory disease were announced by Dr. H. M. Marvin, of New Haven, president of the American Heart Association.

The grants were in response to applications received earlier this year. They were determined from among over 60 requests reviewed by the Research Committee of the American Heart Association's Scientific Council.

New applications for Research Fellows and Established Investigators will be accepted up to September 15. Applications may be made to Dr. Charles A. R. Connor, Medical Director, 1775 Broadway, New York 19, New York.

Announcement recently was made of the creation of the Hebrew University-Hadassah Medical School, the first institution of medical learning in the Jewish State. As soon as conditions permit, a new medical school building will be erected on Mt. Scopus, outside of Jerusalem.

Corporate Practice of Medicine . . .

Encroachment of Institutions Into Specialty Fields Is Target of Strongly Worded Report Adopted by A. M. A. House of Delegates

THE House of Delegates adopted the strongest stand ever taken by the American Medical Association against the corporate practice of medicine at the 1949 Annual Session in Atlantic City. The adopted report of the committee on the Hospitals and Practice of Medicine is directed at practices in some institutions which have permitted encroachment into the medical field in such specialties as radiology, pathology and the like.

Features of the adopted report may be summarized into the following three categories:

1. Recommendation that constituent associations appoint committees on hospital and professional relations to receive complaints with reference to professional or economic relationships existing between physicians and hospitals or medical schools.

2. Recommendation that if local compromise of the complaint is impossible, charges of unethical conduct on the part of either members of the professional staff or hospital management be brought before the Judicial Council of the American Medical Association for examination.

3. Recommendation that the Judicial Council order the withdrawal of the Association's approval of an institution found guilty and not willing to cooperate within ethical and legal limits.

TEXT OF REPORT

The report as adopted by the House of Delegates is as follows:

"The corporate practice of medicine is distinctly illegal in all of the states in the Union with some exceptions. There has been statutory legislation in several states permitting certain modifications in these general laws.

"In order to support this statement the Principles of Medical Ethics of the American Medical Association are quoted as follows:

Chapter I, Section 3
Chapter III, Article V, Section 1
Chapter III, Article VI, Section 2
Chapter III, Article VI, Section 3
Chapter III, Article VI, Section 6

"After consideration of these principles, it must be concluded that **the over-all policy of the American Medical Association shall be that it is illegal, with the exceptions noted, and unethical for any lay corporation to practice medicine and to furnish medical services for a professional fee which shall be so divided as to produce profit for a lay employer,** either individual or institutional, including hospitals and medical schools.

"The ethical principles governing all groups and clinics are exactly the same as those governing the individual.

"In insurance programs, hospital service plans shall provide payment for hospital services only. Medical service plans should supply payments for all of the medical services, including pathological, roentgenological, anesthesiological, and and physio-therapeutic services. **The licensed physician is the only person legally qualified at the present time to render any individual medical service.**

PHYSICIAN INTEREST

"This being so, then the medical profession should be dominant in the physician-hospital relationship under all circumstances, but since the physician and the hospital are interdependent, it is incumbent on both to be completely interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not only other members of the professional staff, whether active or courtesy, but also towards hospital management. The finances of an institution in which a physician does his professional work are definitely of importance to him and to the professional staff, and the proper consideration must be given to these finances if the hospital is to work efficiently and remain the workshop of the physician.

"The recommendations of the staff are usually accepted by the management of the hospital through its boards of managers or trustees. It must also be remembered that to be approved by the boards of medical licensure, the American Medical Association and the American College of Surgeons, certain requirements are mandatory to the institution, namely, adequate pathological and radiological coverage. As a rule, the staff of a hospital elects an executive committee or works under an appointed executive committee to advise the lay officers of the institution on purely professional matters, and recommends who may or may not use the institution for their professional work. **Unfortunately, in many instances, the financial matters of the lay hospital management have been no affair of the staff or of its professional executive committee.** This is wrong and probably the cause of most of the differences of opinion. Every professional man on the appointed staff should have a voice

in the professional management of the institution. The pathologist, roentgenologist, anesthesiologist and the physiatrist, as well as the other professional staff members, should have equal standing as active members of the staff, and the executive committee or physicians of the active staff should be empowered to recommend the physicians heading these departments in any hospital where they exist. That the finances of the hospital are of grave importance to the staff goes without saying. Without proper facilities the services rendered to the public are in jeopardy and these public services are the all-important function of both hospital and staff.

ADJUDICATING COMMITTEES

"It is therefore the opinion of the Committee that most controversies between management and the professional staff, either individually or collectively, should be settled on local levels in accordance with clearly established national policy. To implement the settlement of such controversies, the House of Delegates recommends to each of its constituent state and territorial societies that it appoint a committee on hospital and professional relations. This committee shall be available to receive complaints from any physician, hospital, medical organization, or any other interested person or group with reference to professional or economic relations existing between doctors of medicine and hospitals or medical schools. Upon receipt of such complaint by such committee, the matter shall be investigated and acted upon in such manner as that committee may decide and in accordance with regular and existing modes of procedure.

"There can be no exploitation of the doctor or of the hospital if everyone concerned in both management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services to the public.

JUDICIAL COUNCIL

"Most of these matters could be settled at the hospital or county level. **Therefore it is recommended that after all efforts at the local and state levels have been exhausted, the charges of unethical conduct by either members of the professional staff or by hospital management should be brought to the Judicial Council for examination. If the Judicial Council, working with similar committees of hospital agencies, cannot adjudicate the specific matter and finds ethical and legal compromise impossible, then suitable action should be taken against the physician or institution found guilty.** The authority for this is found in the Constitution and By-Laws of the American Medical Association as follows: Chapter III, relating to 'Disciplinary Action'; Chapter X, Section 4, relating to 'Standing Committees.'

"If a hospital or other lay group is found guilty and will not cooperate within ethical and legal limits, it is recommended that the Judicial Council shall order the withdrawal of the Association's approval of that institution. This authority has been given by the By-Laws of the Judicial Council.

MASSACHUSETTS RECOMMENDATIONS

"This Committee can find no better recommendations to establish principles governing proper relations between physicians and hospitals than those adopted by the Massachusetts Medical Society, which read as follows:

'1. That the medical costs of hospital care be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.

'2. That basic principle in the establishment of charges should be that each department be self-supporting. This principle should be so applied that neither the hospital nor the physician rendering the service shall exploit the patient or each other.

'3. That fees for medical services which are collected by the hospital be established by joint action of a representative committee of the staff, to include the head of the department, and the administrator and the governing body of the hospital.

'4. That the basis of financial arrangement between hospital and physician may be salary, commission, fees, or such other method as will best meet the local situation, with due regard to the needs of the patient, the community, the hospital and the physician.

'5. That bills for all medical services be rendered in the name of the physician or physicians performing the services.'

"It is the opinion of your Committee that acceptance and practice of these principles will effect the separation of hospital services and medical care rendered in hospitals, as well as the responsibility for the payment of medical services and non-medical hospital services as defined above, including prepayment and other insurance plans, and should become the basis of policy to be followed in all activities of the headquarters staff."

Age 11 is the safest year of life. A combination of circumstances contribute to make this age the point of lowest mortality. By then, the death rate from the diseases and conditions of early life have been reduced to minor proportions, while the chronic conditions have yet to appear as an item of importance in the mortality picture.—*Metropolitan Life Ins. Co.*

Standards for Health Plans . . .

A. M. A. Delegates Formulate Guide To Help Doctors in Evaluating Lay-Sponsored Medical Programs With Which They May Have Dealings

PHYSICIANS in Ohio will be interested in a set of standards laid down by the House of Delegates of the A. M. A. at its Atlantic City meeting this year, as a guide to doctors and as an aid in evaluating lay-sponsored health and medical plans.

Development of the set of principles dates back to 1946 when the Committee on Rural Medical Service of the A. M. A. suggested to the Board of Trustees and the House of Delegates that "some minimum standards" be adopted. The task of setting up the standards was placed in the hands of the Council on Medical Service.

A survey made by that council indicated that some 171 lay-sponsored voluntary health plans had been organized in 43 states and were serving an estimated 1,600,000 persons.

"Certainly more important, however," the report states, "was (and is) the growing emphasis on the so-called fringe benefits in collective bargaining. While the American Medical Association has no part in the collective bargaining effort itself, we must recognize a responsibility in seeing to it that the principles under which any health plans, resulting from such collective bargaining are organized, give assurance to the individual participants that the quality of medical care will not be adversely affected."

The plans are not to be confused with prepayment medical care plans sponsored by the medical profession, such as Ohio Medical Indemnity, Inc., sponsored by the Ohio State Medical Association, nor with hospital care plans as the Blue Cross plans.

20 PRINCIPLES

The 20 "principles for lay-sponsored voluntary health plans" are as follows:

1. The plan shall be nonprofit, paying no dividends to beneficiaries or others; all surplus earnings shall be devoted either to improving the services, to making compensation of physicians and other staff members more adequate for their responsibilities and services, to purchasing facilities and equipment, to increasing the scope of benefits, or to building adequate reserve funds. All income to the plan shall be devoted to services for beneficiaries.

2. The plan shall comply with the Principles of Medical Ethics of the American Medical Association, which provide that it is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him.

3. If incorporated, the plan shall be adequately financed and organized without capital stock.

4. The plan shall be operated under an autonomous administration or trust, with segregated funds, and shall be devoted exclusively to the provision of health service.

5. Promotion, sales, organization and administrative expense of the plan shall be kept at a minimum as judged by the acrediting body.

HIGHEST POSSIBLE LEVEL

6. The quality of medical service shall be maintained at the highest possible level. All participating physicians shall be doctors of medicine duly licensed to practice medicine in any state in which the plan operates. Each physician engaged in the practice of a specialty shall be required to have adequate qualifications for that specialty. The personnel and facilities of the plan shall be adequate to insure a high quality of medical care.

7. The plan shall provide all services as set forth in the agreement with the beneficiary. When, in the opinion of the medical staff, a professional service set forth is not available because of an emergency or because of the need for highly technical procedure, or for any other reason, then such service shall be otherwise provided by the plan.

CLEAR STATEMENTS

8. The plan, in its agreement entered into with the beneficiary and which shall be distributed to each beneficiary, shall state clearly the services and benefits to be provided and the conditions under which they will be provided. All exclusions, limitations, waiting periods and deductible provisions shall be clearly stated in the agreement with the beneficiary and in promotional and descriptive literature.

9. The plan shall, in its agreement with the beneficiary, state clearly the amount of dues or subscriptions to be paid. The amount of dues or subscription shall be adequate to provide for the benefits and services offered and to insure proper financing of the risks involved.

10. No promotional material shall invite attention to the professional skill, qualifications or attainments of the physicians participating in the plan.

11. Participating physicians may be compen-

sated in any manner not contrary to the Principles of Medical Ethics of the American Medical Association relating to contract practice.

12. Any duly licensed physician in the community who wishes to participate in the plan, who meets its professional and personnel standards and who agrees to abide by its terms and the requirements of its beneficiaries shall be admitted to the plan.

13. The names of all participating physicians of the plan shall be made available to the prospective beneficiary. The beneficiary shall, within reasonable geographic and professional limitations, have free choice among participating physicians.

STAFF TO BE UNHAMPERED

14. There shall be no interference by the governing body with the medical staff in the practice of medicine. The traditional and confidential relationship of the physician and patient shall be preserved.

15. Adequate provision shall be made for effective participation of the medical staff in the deliberations of the governing body. It is recommended that the membership of the governing body include representatives of the medical profession.

16. All services rendered by the participating physician, not included in the beneficiary's contract, shall be payable by the beneficiary to the participating physician on a fee for service basis.

17. The method of operation of any hospital owned or under contract to the plan shall be in accordance with sound public policy.

18. The plans shall provide for like rates, benefits, terms and conditions for all persons in the same class.

19. Investment of reserve funds shall be made only in securities deemed prudent for such purposes.

20. Any plan desiring approval under these principles shall agree to such periodic reviews and to abide by such regulations as may be deemed necessary by an appropriate accrediting body of the American Medical Association in consultation with representatives of the sponsors of the plan.

Navy Examination

The Bureau of Medicine and Surgery, Navy Department, has announced that examinations for the selection of candidates for appointment to the grade of lieutenant (junior grade) in the Medical Corps of the U. S. Navy will be conducted at all U. S. Naval Hospitals during the period September 12 to 16 inclusive.

Detailed information as to form and procedure of application may be obtained from the offices of Naval Officer Procurement or from the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C. (Attn: Code-3424).

Central Radiological Society Elects Officers

Dr. Paul D. Meyer, Columbus, was elected president of the Central Ohio Radiological Society at its final meeting of the season in the Seneca Hotel in Columbus. Other officers elected are: Dr. Frank A. Riebel, Columbus, vice-president, and Dr. John B. Cooley, Springfield, secretary-treasurer. Councilors are Dr. Thurman R. Fletcher, Columbus; Dr. Maurice A. Loebell, Zanesville, and Dr. Leslie D. Urban, Ashland, Ky.

Meetings are scheduled for the second Thursday of every second month, October to June, inclusive. All physicians interested in radiology are invited.

At the final meeting in June, a team from Ohio State University College of Medicine conducted the program with the following participants and subjects: Dr. John Neff, "Case Presentation of Pituitary Radiation for Exophthalmos Following Removal of Goiter"; Dr. Howard Bangs, "Improved Technique of Excretory Urography"; and Dr. Joseph Martin, "Interstitial Radiation of Carcinoma of Cervix With Cobalt 60."

Ohioans Among Recipients of Federal Grants

Research grants totaling $2,040,900 to finance medical and allied research projects at non-Federal institutions in 30 states, Alaska, Puerto Rico, and the District of Columbia were announced by the Federal Security Administrator.

The grants were awarded following recommendation by the National Advisory Health Council and approval by Surgeon General Leonard A. Scheele of the Public Health Service.

The grants include the following in Ohio:

Christ Hospital Institute of Medical Research, Cincinnati, L. H. Schmidt, $42,000; investigations on the chemotherapy and biology of primate malaria as observed in Plasmodium cynomolgi infections in the rhesus monkey.

May Institute for Medical Research of the Jewish Hospital, Cincinnati, I. Arthur Mirsky, $18,522; role of intracellular proteinases (and other insulin inactivators) in the etiology of diabetes mellitus.

Western Reserve University School of Medicine, Cleveland, Arnold D. Welch, $19,742; biological significance of pteroylglutamic acid; study of extrinsic and antipernicious anemia factors.

Western Reserve University, Ernest Bueding, $28,566; comparative biochemistry of parasitic helminths and chemotherapy of chistosomiasis.

Western Reserve University School of Medicine, Ralph I. Dorfman, $10,530; metabolism of the steroid hormones.

"Severe intractable asthma

requires more strenuous measures. . . . Aminophyllin in doses of 0.25 Gm. dissolved in 10 cc. of water is often very effective when injected intravenously."[1]

To relax spasm, relieve congestion and restore deep, regular breathing,

SEARLE **AMINOPHYLLIN***

has proved a valuable drug—generally effective even in epinephrine-refractory cases.

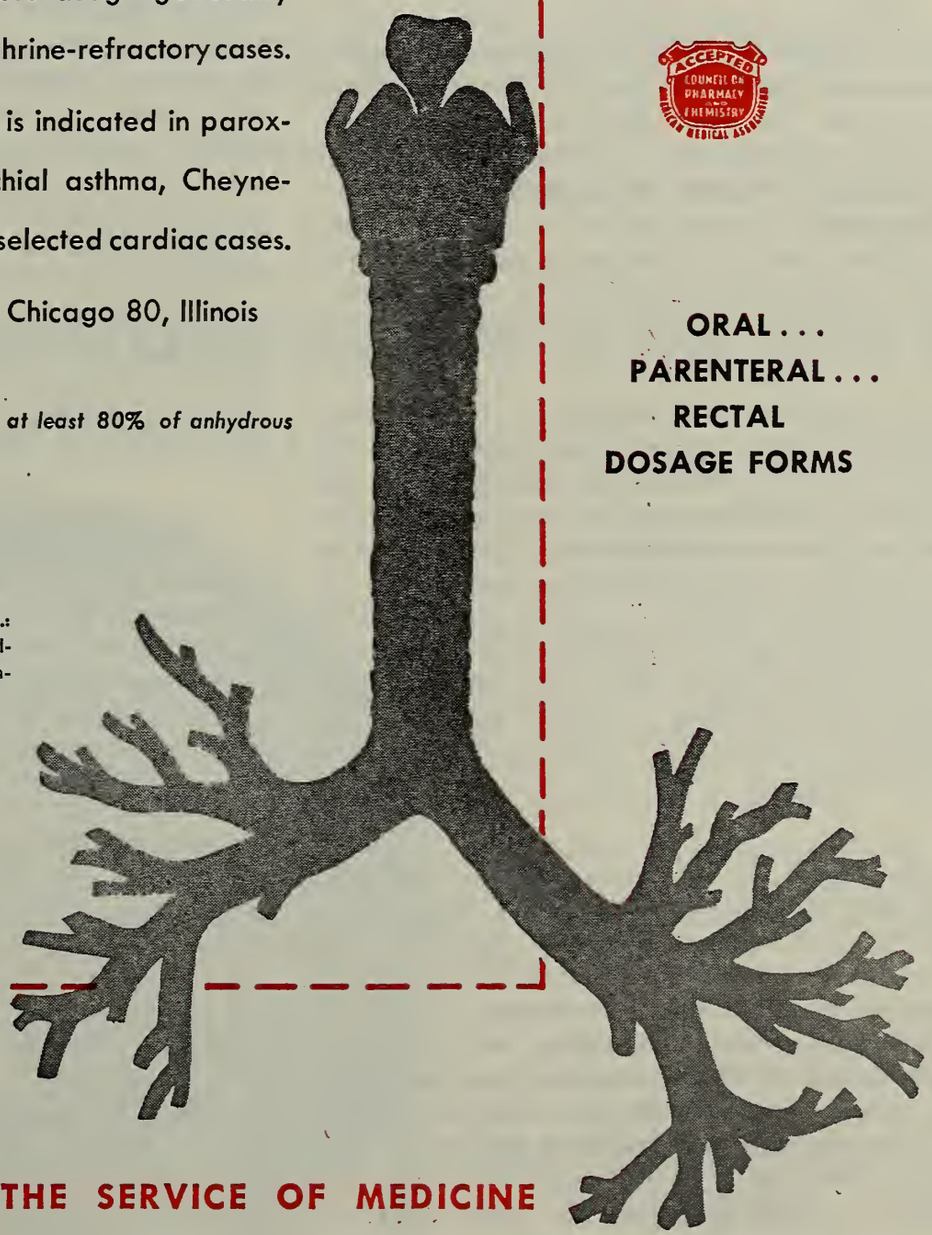
Searle Aminophyllin is indicated in paroxysmal dyspnea, bronchial asthma, Cheyne-Stokes respiration and selected cardiac cases.

G. D. Searle & Co., Chicago 80, Illinois

*Searle Aminophyllin contains at least 80% of anhydrous theophylline.

ACCEPTED Council on Pharmacy and Chemistry American Medical Association

ORAL . . .
PARENTERAL . . .
RECTAL
DOSAGE FORMS



1. Rackemann, F. M., in Cecil, R. L.: Textbook of Medicine, ed. 7, Philadelphia, W. B. Saunders Company, 1948, p. 539.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

On the Firing Line . . .

Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"We see where the advocates for the Truman administration's so-called 'health insurance' program now are touting it as the 'only alternative to state medicine.'

"This reminds us of the favorite gag of a little six-year-old we know. She asks you solemnly—'If I have three kittens and call one of them a puppy, how many kittens do I have left?'

"If you play up, as expected, and say 'Two,' she will giggle and say, 'Oh no,—three! I just *called* the kitten a puppy. That doesn't make it a puppy.' "—*The Columbus Dispatch.*

* * *

"Where we will wind up, no one can tell. But if some of the new programs seriously proposed should be adopted, there is danger that the individual, whether farmer, worker, manufacturer, lawyer or doctor, soon will be an economic slave pulling an oar in the galley of the state."—*Former Secretary of State James F. Byrnes in an address at the bicentennial celebration of Washington and Lee University, June 18, 1949.*

* * *

"In Germany, the birthplace of compulsory health insurance, there was one non-medical employe for every 100 insured persons. Our own Veterans Administration has one employe for every ninety-seven beneficiaries. At those ratios, a compulsory health insurance scheme in the United States would require between 1,000,000 and 1,500,000 government payrollers and administrative costs of at least three billion dollars annually."—*R. B. Robins, M. D., Speaker of the Congress of Delegates, American Academy of General Practice.*

* * *

"He pointed out that total taxation in Britain, local and national, was now more than 40 per cent of the national income. At that level, the redistribution of income entailed in the payment for social services already fell, to a considerable extent, upon those who were also the recipients of those services. In other words, the people were paying for what they were getting, although they had been sold on the idea that it was free."—*Saturday Evening Post editorial on budget speech of Sir Stafford Cripps.*

"Without Marshall Plan aid Britain could not afford the wholesale benefits of its new National Health Service. This year the scheme will cost nearly $1,500,000,000 or more than 10 per cent of the country's entire national budget. When in full operation it will probably cost about $2,500,000,000 a year.

"At the same rate a socialized scheme here would cost about ten billion dollars a year, though higher American price levels would probably push it well above that figure."—*William Alan Richardson, editor of Medical Economics.*

* * *

"The spectre of thousands of little men and women swarming over the country, making jobs out of compulsory medicine, making the costs exorbitant, and making people's lives miserable with their rule books and myopic view of humanity seems not too difficult to conjure. Before we bring this picture upon ourselves, let us extend the thousands of voluntary hospital and medical plans, let us tailor them to the needs of each individual group, with costs related to and controlled by use, and with individuals budgeting and taking care of their own needs, with the right to say who shall treat them."—*Robert A. Hornby, vice-president, Pacific Lighting Corporation, San Francisco.*

* * *

"British doctors are now writing prescriptions at the rate of 150,000,000 a year. Demands for 'free' medicine are so great that doctors are prescribing ever larger bottles to keep patients from coming to the office so often."—*William Alan Richardson, editor of Medical Economics.*

* * *

"Medical care is of great importance. Yet good health and good medical care are far from synonymous. Far be it from me to underemphasize the enormous contribution of physicians to good health. Is it not significant, however, that during the war, when we had only two-thirds the normal number of doctors available for the civilian population, there was actually a decline in maternal mortality of 50 per cent and in infant mortality of 20 per cent?"—*Earl O. Shreve, president, Chamber of Commerce of the United States.*

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Feinberg, S. M.: Postgrad. Med. 3: 92 (1948).

"Apparently, desensitization treatment is still the method of choice, and the antihistaminic drugs cannot be considered as substitutes."
Levin, L.; Kelly, J. F., and Schwartz, E.: New York State J. Med. 48: 1474 (1948).

The antihistaminic drugs "are valuable additions to our armamentarium, but do not . . . supplant the specific desensitizing injections."
Brown, G. T.: M. Ann. District of Columbia 16:675 (1947).

Pollen desensitization "still remains the treatment of choice in hay fever."
Rosen, F. L.: J. M. Soc. New Jersey 45: 390 (1948).

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SYMPTOMS WHICH NEED STUDY

The publicity given to the recent panel discussion staged by the Columbus Academy of Medicine, in which a newspaper editor, lawyer, preacher and labor official took some swift punches at the chin of the medical profession, has caused more chatter in the scrubrooms and across the luncheon tables in Columbus than anything which has happened since the report of the busting of the dam during the 1913 flood.

Some of the charges which were made were silly; others easily explained; still others entirely justifiable—at least in specific instances. Regardless of right or wrong, the fact remains that the four speakers merely said to the physicians what too many other folks are saying about them—but on the street, on the front porch, and at social chit-chats. Which leads even the fellow who is extremely partial to the medical profession to think that somebody is not doing right by our Nell.

An interesting sidelight is that more than one faithful conscientious physician received phone calls from grateful patients after the newspapers headlined the episode, assuring him that they did not consider him one of the offending M. D.'s. Moreover, there was considerable comment on Broad and High streets, commending the medical profession for having had the courage to put itself through the inquisition. All of which shows that there is more glory to be gained by facing issues head-on than by playing ring-'round-the-rosey.

What happened is not so important as what will—can—be done to eliminate the abuses which actually do exist. As Dr. Gil Kirk, Columbus Academy prexy observed, the criticisms make "a little personal introspection worth while."

Symptoms in Columbus are no different from those in other parts of the state. It might be well for the medical profession in general to do a bit of self-diagnosis and then tackle the ailments. Public confidence is not retained or won by running away from curable situations.

PROBLEM OF THE MEDICAL INDIGENT

Some statistics released recently by the Franklin County chapter of the National Foundation for Infantile Paralysis show that the average case of infantile paralysis costs about $2,000 and that Franklin County has spent as high as $4,800 on one case.

These figures, which presumably are accurate, are convincing proof of the need for programs to meet the problems of the so-called medically indigent. Think of the families which could—and do—find themselves on the brink of economic ruin when a prolonged, costly illness or disability hits.

Voluntary prepayment medical and hospital programs can do part of the job—and are doing so. A program such as the one proposed by Senator Taft wherein public funds would be used to provide coverage for the extended types of disabilities, supplementing the non-governmental plans designed primarily for the acute cases, might well be the rest of the answer.

It's an issue—a problem, which must be faced sooner or later. It behooves the medical profession to cooperate with those who are anxious to see the matter solved without political dictatorship but along sound, conservative but at the same time effective lines.

PATIENTS APPRECIATE IT; THEY EXPECT IT

Observes the *Alameda County (Calif.) Medical Society Bulletin*: "Alameda C. M. S. has been trying to drum into us: Talk all fees over first. Patients appreciate it. They expect it."

Those words of wisdom are a tip for every single physician. Think of the grief which might have been avoided for a good many patients and doctors if the question of fees had been frankly discussed across the desk in all cases, especially the serious, unusual cases.

Give it a whirl. You may find that it will pay dividends—in cash and good will.

SOUNDS TO US LIKE HOBSON'S CHOICE

In testimony before congressional committees on proposed compulsory insurance legislation, Mr. Lloyd C. Halvorson, economist on the staff of the National Grange, stated the position of the National Grange as follows:

"The National Grange has adopted resolutions opposing socialized medicine. To many members this means opposition to compulsory health insurance though not to all."

Mr. Halvorson then pointed out what the Grange considers as probably objections to compulsory health insurance, referring to a resolution adopted by the organization which resolved "that people with comprehensive voluntary health service be exempted from any plan for com-

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pulsory health insurance should such health program be established.

"This resolution is self-explanatory," testified Mr. Halvorson, "and I might add that if people could choose between voluntary plans and government insurance, I doubt if the Grange would have any serious objection to government health insurance."

The above statement certainly must be wishful thinking on the part of Mr. Halvorson and his associates as they are too smart to really believe that a compulsory health insurance program will leave the people any choice in the matter or that most people will be able to exercise any choice in the matter, even should that be their desire, because of the economic factors involved.

How many will find it desirable or convenient to pay double or to make a contribution to a so-called service they never expect to use? Most farmers are too astute businessmen to fall for promises which haven't a ghost of a chance of being fulfilled, in our opinion.

JIM BAUMAN—MANY OF HIS ACORNS NOW OAKS

Retirement of James E. Bauman from the Ohio Department of Health marks the passing from the state service of its oldest employee from the standpoint of years of service. Jim started in the state service in 1892 as clerk-bookkeeper for the then State Board of Health. While plugging away he studied law and became an attorney. Over the years he has served as acting-director during periods when the job of director was unfilled by a physician; as legal counsel of the department, chief of the Division of Administration, and secretary of the Public Health Council.

Most of the public health laws of Ohio have been drafted by Jim. He knows more about public health policies, procedures, and programs than any other person in the state. His advice and counsel on health matters have proved indispensable to the health professions and health workers in Ohio for many moons.

In leaving the state service, Jim takes with him the respect and esteem of hundreds of those who have been his co-workers and a multitude of others who have sought his help and advice over the years. The state has lost a faithful and worthy executive.

As he continues to watch the acorns which he helped plant grow into bigger oaks, Jim will have the satisfaction of knowing that he did his numerous chores well and that he made many a splendid contribution to the never-ending effort to give the people of Ohio a better, more efficient public health program.

A. F. OF L. STATES ITS INTENTIONS IN '50

Writing as a guest columnist for the *Columbus Citizen*, William Green, president of the American Federation of Labor, states organized labor's intentions in the political arena as follows:

"What organized labor and the country as a whole needs is a large majority of liberals in Congress, regardless of what their party affiliations may be.

"To this end the American Federation of Labor will dedicate its efforts in the 1950 campaign. We are going to carry on the fight through Labor's League for Political Education which made such a remarkable record in 1948—its first political campaign.

"Yes, the American Federation of Labor is in politics to stay. But even more than that we realize that in order to become an influential factor in American politics our organization must stay strong. We cannot afford to pass up off-year elections such as 1950 and permit the reactionaries to gain ground because of public apathy."

Those who may disagree—and honestly—with the views of Mr. Green and his associates on certain national issues should take a leaf from his book and see to it that they also do something about the off-year elections.

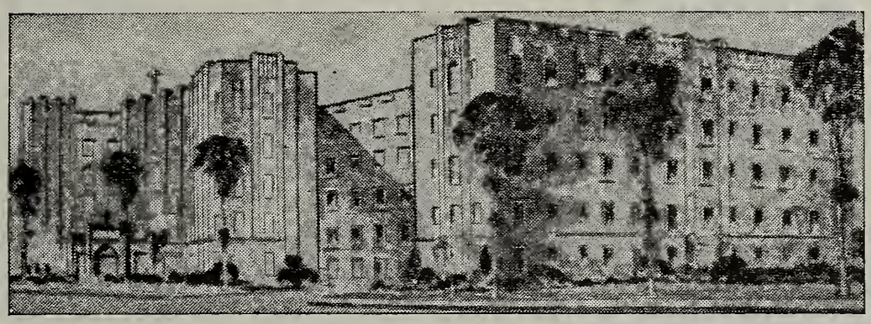
HAVE A LITTLE TALK WITH YOUR PASTOR

Testifying before a congressional committee, the Rev. Alson J. Smith, Stamford, Conn., spokesman for the Methodist Federation for Social Action, expressed the view that most American churchmen support the idea of compulsory health insurance.

We don't know how the Rev. Mr. Smith would define "most." Nevertheless, here's another tip-off. Better quiz your own minister—straighten him out in case he trails along with Brother Smith.

Obviously, the clergy is exposed to many pathetic situations—hear plenty of stories of sorrow and hardship. They want to see something done to remedy these situations and problems. So does the medical profession.

Tell your pastor what the medical profession (in Ohio at least) stands for and what it is trying to do to meet these problems. Some ministers think the medical profession is still in the "do nothing" stage. If they are set straight on that, there won't be so many of them (if there are "many") who will go for government medical schemes—providing, of course, they also are wised-up on the dangers of political medicine.



The John N. Norton Memorial Infirmary announces the opening of a complete unit for the Treatment of Alcoholism

A new 125 bed addition financed by public subscription, supplemented by Federal and State grants, includes a 20 bed unit for treatment of alcoholism. A five-day period of treatment, which has proved to have the most permanent results, will be given under the direction of an internist especially prepared for this service. All other services of the hospital and consultation from any division of the Medical Staff are available if required; particularly consultation from the newly organized Psychiatric Department, which is being operated on a post-graduate teaching basis in affiliation with the University of Louisville School of Medicine. An all inclusive fee will be charged for the standard five-day period. There are separated facilities for the care of women . . . For full information, write or telephone

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Do You Know? . . .

Membership in the Woman's Auxiliary to the American Medical Association was 48,659 in June, 1949, an increase of 6,237 during the year.

* * *

Copies of the Principles of Medical Ethics of the American Medical Association, as revised by the Judicial Council and approved at the Atlantic City session, may be obtained by addressing the secretary, Dr. George F. Lull, 535 N. Dearborn St., Chicago 10.

* * *

The *Statistical Bulletin* of the Metropolitan Life Insurance Company points out that progress in life conservation has proceeded at so rapid a pace in this country that well over one quarter of a million lives were saved in 1949 alone because of the improvement in mortality since 1940. There were 1,445,370 deaths reported in the United States in 1947. Had the population experienced the death rates, by sex and age, observed seven years earlier, the deaths would have totaled 1,712,396.

* * *

Dues of the California Medical Association for 1950 have been set at $45 per year.

* * *

The 27th Annual Scientific and Clinical Session of the American Congress of Physical Medicine will be held at the Netherland Plaza, Cincinnati, September 6-10, 1949. The program includes instruction courses for physicians and registered physical therapy technicians. For details write the Congress at 30 North Michigan Ave., Chicago 2.

* * *

Governor Warren's 1949 compulsory health insurance plan was turned down by the California state legislature. Similar proposals were defeated in 1945 and 1947.

* * *

The Physicians Forum, a national organization of physicians advocating compulsory health insurance, supported an independent slate of candidates in the recent annual election of officers of the New York County Medical Society, largest county group in the nation. The independent's candidate for the presidency of the society received 726 votes. His opponent polled 2,435 votes.

* * *

Colonel Frank E. Hamilton, formerly of Columbus, who has headed the surgical service at Walter Reed General Hospital for several years has been transferred to like duty in the Gorgas Hospital in the Panama Canal Zone. His successor at Walter Reed is Colonel Sam F. Seeley who was chief of the Procurement and Assignment Service during the early months of the war.

* * *

Labor leaders, beaten on big issues in Congress, figure a switch in 15 House seats and five Senatorships in the 1950 elections, will give them control of the next Congress and assure a labor program. Their get-out-the-vote drive is being concentrated in certain states, including Ohio, where Senator Robert A. Taft is the target.

* * *

The next Scientific Assembly of the American Academy of General Practice will be held in St. Louis, Mo., February 20-23, 1950. Headquarters will be in the Kiel Auditorium.

* * *

Beginning July 1, 1950, the Veterans Administration will offer 259 internships to qualified graduates of recognized medical schools in 13 of its hospitals.

* * *

The Council on Medical Education and Hospitals of the American Medical Association has removed the Hahnemann Medical College of Philadelphia from probation and restored the school to a status of full approval.

* * *

Included in a package of health education material being mailed by the Ohio Congress of Parents and Teachers to the health chairmen of 1800 local units, is a pamphlet on "Immunization," with the compliments of the Committee on School Health of the Ohio State Medical Association.

* * *

Under the program for the unification of the Armed Forces medical services, the Aiea Naval Hospital in Hawaii was closed and Tripler General Hospital became the Armed Forces hospital for the Hawaiian area to serve personnel of the Army, Navy, Air Force, Marine Corps and Coast Guard. In addition it will serve patients of the U. S. Public Health Service and veterans of the islands.

* * *

The 19th annual meeting of the Biological Photographic Association will be held in Cleveland, September 7, in the Hotel Cleveland.

* * *

The 6th Annual Meeting of the American Medical Writers' Association (formerly known as the Mississippi Valley Medical Editors' Association) will be held at the Jefferson Hotel, St. Louis, on Wednesday, September 28, during the 14th Annual Meeting of the Mississippi Valley Medical Society (September 28-30).

In Memoriam . . .

James Everette Burgman, M. D., Springfield; Indiana University School of Medicine, 1918; aged 54; died June 30; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Clark County Medical Society in 1929 and its treasurer 1930-31; diplomate of the American Board of Otolaryngology; member of the American Academy of Ophthalmology and Oto-Laryngology. Dr. Burgman went to Springfield in 1920 after serving during World War I as a Navy lieutenant-commander. He was a member of the Catholic Church and the American Legion. Surviving are two daughters.

Frederick L. Case, M. D., Columbus; Ohio Medical University, Columbus, 1900; aged 87; died July 7. Dr. Case had retired from active practice several years ago. Surviving are his widow and a sister.

Rae Hazen Cather, M. D., Barberton; College of Physicians and Surgeons of Baltimore, 1914; aged 62; died June 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Cather practiced his profession in Barberton for 22 years and was active in civic and fraternal work. He was a member of the Barberton Chamber of Commerce, the Rotary Club, the Eagles, American Legion, Masonic orders, Elks, and the Fraternal Order of Police Associates, the Presbyterian Church, and was a veteran of World War I. Surviving are a daughter, two brothers and two sisters.

Samuel Elgart, M. D., Cincinnati; Tufts College Medical School, Boston, 1938; aged 37; died June 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Elgart was doing research work at the May Institute of Medical Research at Jewish Hospital. He had recently returned from Oak Ridge, Tenn., where he conducted experiments in the use of radioactive isotopes.

John Woodford Holloway, M. D., Cleveland; Western Reserve University School of Medicine, 1923; aged 53; died June 2; member of the Ohio State Medical Association and a Fellow of the American Medical Association; chairman of the Section on Surgery of the Ohio State Medical Association; clinical professor of surgery at Western Reserve University School of Medicine.

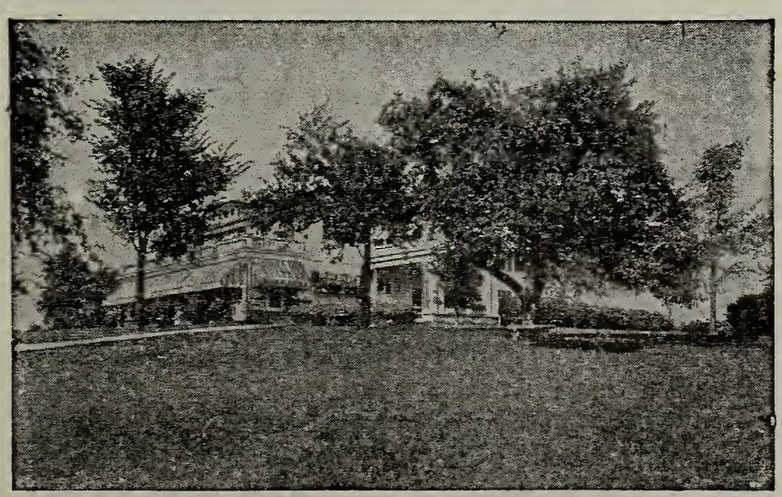
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Dr. Holloway practiced his profession in Cleveland from the completion of his education. In addition to his work in professional societies, he held memberships in several fraternal and honorary groups. Surviving are his widow and a daughter.

Frank C. Huth, M. D., Cambridge; University of Louisville School of Medicine, 1893; aged 83; died June 20; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Guernsey County Medical Society in 1928. Dr. Huth's career in the medical profession extended well over a half century, during which much of his time was spent in hospital organization and management. He opened a hospital in Woodsfield in 1904. In 1912 he assumed the management of Cambridge City Hospital, and in 1920 acquired an interest in the Wells Hospital and later assumed full control of the institution now known as the St. Francis Hospital. He was a member of the Catholic Church, the Holy Name Society and the Knights of Columbus. Surviving are his widow; a son, Dr. Paul O. Huth, also of Cambridge, and a sister.

David White Peppard, M. D., Mansfield; Western Reserve University School of Medicine, 1901; aged 72; died July 3; member of the Ohio State Medical Association and a Fellow of the American Medical Association; delegate of the Richland County Medical Society to the O. S. M. A. in 1926. Dr. Peppard practiced medicine in Mansfield for approximately 46 years. Surviving are his widow, a son and three daughters.

Clarence Larimore Perry, M. D., Miami Beach, Fla.; Ohio State University College of Medicine, 1924; aged 52; died July 6; former member of the Ohio State Medical Association; member of the Florida State Medical Association and Fellow of the American Medical Association; member of the American College of Surgeons and the Southeastern Surgical Congress. Dr. Perry served as physician at the Ohio State Penitentiary, Columbus, 1926-27. Surviving are his widow, two daughters and his mother.

Wilbur Berry Roads, M. D., Hillsboro; University of Illinois College of Medicine, 1907; aged 68; died June 17; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary-treasurer of the Highland County Medical Society from 1924 through 1948. Dr. Roads practiced at Leesburg and Hollansburg before going to Hillsboro approximately 33 years ago. He was a member of the Masonic Lodge. Surviving are his widow, a daughter, a brother, two half-brothers, a half-sister and his stepmother.

Leonidas C. Walker, M. D., Xenia; Hahnemann Medical College and Hospital, Chicago, 1882;

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Preface by
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So huge are the potentials of recent scientific and technological advances that the authors scoff at the pessimists who think the world cannot feed itself. Modern man, they insist, has it in his power to banish want—to take the hunger out of history.

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"It contains a large number of persuasive, accurate, and pertinent facts and analyses. . . Everybody in the food trade, every doctor, every teacher of nutrition and every food scientist should read it."—*John D. Black, N.Y. Times Book Review.*

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aged 94; died July 1; former member of the Ohio State Medical Association and the American Medical Association through 1932. Dr. Walker had practiced his profession in Jamestown before retiring a number of years ago. He was a member of the Masonic Lodge. Surviving are a daughter and a son.

Mara L. S. Wingate, M. D., Cleveland; Cleveland University of Medicine and Surgery, 1897; aged 83; died June 25. Dr. Wingate practiced for many years in Cleveland before her retirement. She was the wife of the late Dr. Daniel Miles Wingate. Surviving is one daughter.

Sixth District Scheduled Program For November 30

The annual Post Graduate Day for the Sixth Councilor District of the Ohio State Medical Association will be held on Wednesday, November 30, at Youngstown. The session will be conducted by a team from the Lahey Clinic of Boston, Mass.

Details on the program will be announced at a later time.

Society for Crippled Children

The Annual Convention of the National Society for Crippled Children and Adults will be held November 7, 8 and 9, at the Commodore Hotel, New York, according to an announcement made from Chicago headquarters by Lawrence J. Linck, executive director.

Cancer Grants Announced

Cancer training programs are now carried out in 74 of the country's 79 medical schools, including the three medical schools in Ohio, with the aid of grants from the National Cancer Institute, the Federal Security Administrator announced. Allocations totaling $872,477 have been made. The following grants have been made in Ohio:

University of Cincinnati College of Medicine, Dr. B. N. Carter, $25,000; continuing grant-supported training program.

Western Reserve University School of Medicine, Dr. Robert W. Heinle, $25,000; continuing grant-supported program.

Ohio State University College of Medicine, Dr. Herman A. Hoster, $25,000; expanding present training program.

Michigan Annual Session

The 84th Annual Session of the Michigan State Medical Society will be held in Grand Rapids, September 21-23. Among guest speakers on the program is Dr. Robert M. Zollinger, Ohio State University College of Medicine. Further information may be obtained from the Society at 2020 Olds Tower, Lansing, Mich.

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Medical Board Examinations . . .

Total of 215 Graduates of Medical Schools Seek Licenses in Ohio; 21 Osteopaths and 116 Limited Practitioners Also Take Examinations

A TOTAL of 215 applicants for licenses to practice medicine and surgery in Ohio took the examinations of the State Medical Board, held in Columbus, June 15-18. Of this number, 48 were graduates of Ohio State University College of Medicine, 76 of the University of Cincinnati College of Medicine, 62 of Western Reserve University School of Medicine and 29 were out-of-state applicants.

The results of the examinations were scheduled to be considered by the Board at a meeting on August 2.

In addition, examinations to practice osteopathic medicine and surgery were taken by 21 persons. This number included 11 new applicants, four who took special examinations and six who were seeking endorsement of licenses.

Examinations for certificate of limited practice were taken by the following numbers in the branches indicated: 27 mechanotherapy, 40 chiropractic, three chiropody, eight cosmetic therapy and 38 massage.

Following are the written questions asked of those who were examined for licenses to practice medicine and surgery:

ANATOMY

1. Describe the thyroid gland, giving its anatomical relationship and innervation.
2. Describe the blood supply of the female genitalia.
3. Discuss the lymphatic drainage of the intestines and mesentery.
4. Describe the pituitary gland, giving its origin and relationship.
5. Give the course, structure, and relationship of the Eustachian tube to other parts.

PHYSIOLOGY

1. Discuss muscular fatigue.
2. What is the flexor reflex?
3. What is sleep and what effects does it have on the functions of the body?
4. Give the indications for use of intravenous whole blood or saline—post-operatively.
5. What are the physiological actions of anoxia?
6. How is the venous return of blood to the heart controlled?
7. What is the physiological result of aortic insufficiency?
8. Discuss the mechanism of heat loss in the body.
9. How is water balance maintained in the body?
10. What are the physiological effects of parathyroid insufficiency?

BACTERIOLOGY

1. Define immunity, active and passive; sensitization; droplet infection; ptomaine poisoning; antigen.
2. Define aerobic and anaerobic bacteria. Give two examples of each.
3. Give method of detecting chronic carriers of: (a) diphtheria, (b) typhoid fever, (c) malaria.
4. Name three organisms that may cause meningitis. Describe method of establishing diagnosis.
5. Discuss the method of examining sputum with special reference to two important pathogenic bacteria and pathologic material present which may throw light on the state or progress of the disease indicated.

DIAGNOSIS

1. Give the history and physical findings of lobar pneumonia in the lower lobe.
2. Give subjective symptoms and physical findings in abdominal aortic aneurism.
3. Give the signs and symptoms in acute hemorrhagic pancreatitis.
4. What are the end results of acute rheumatic fever and so-called chronic rheumatoid arthritis?
5. Differentiate chronic gastritis and hiatus hernia (symptomatically).
6. Give signs, symptoms and physical findings of pericarditis with serum effusion.
7. Give physical findings in paresis and tabes dorsalis.
8. Differentiate chronic spastic colon and an organic obstruction of the colon.
9. How would you determine irregularity of the heart due to organic lesion from same due to functional conditions?
10. Differentiate spasm of coronary arteries, acute embolic obstruction, and chronic progressive closing of lumen.

CHEMISTRY

1. Discuss the reagents and the tests (general principle only) that may be used in the solution of two of the problems listed: (a) the detection of lactose in a urine which may also contain glucose; (b) the detection of biliary pigments in urine; (c) the detection of urobilinogen in urine.
2. What is meant by the term A-G Ratio? What is the significance of a reversed A-G ratio?
3. Define nitrogen balance. How is it determined? What is the significance of a negative nitrogen balance?
4. What are the important functions of amino acids in metabolism other than the synthesis of tissue proteins of growth?
5. Distinguish between endogenous and exogenous metabolism. Name a product of endogenous metabolis.

MATERIA MEDICA AND THERAPEUTICS

1. Define pharmaceutical incompatibility. Give an example.
2. Name a typical parasympathetic depressant. (a) Dosage, (b) Effect on heart.

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3. Give the management of the unconscious patient.
4. Give four contra-indications to the use of dicoumarin.
5. Give the specific therapy for bacterial infections of the central nervous system. (a) etiology: Beta streptococci; H. influenza; meningococci.
6. Describe briefly the effects of morphine sulphate: (a) therapeutic dosage; (b) toxic dosage.
7. What are the chief toxic effects of each of the following: (a) chloroform, (b) picrotoxin, (c) pentothal.
8. Give the treatment of post-operative atelectasis.
9. Give mechanism of anaphylaxis. (a) Treatment of allergic intoxication.
10. Describe the fate of the benzene derivatives in the body.

PRACTICE

1. Give etiology and symptoms of tetanus.
2. Enumerate early symptoms of acute and chronic oxygen want.
3. Give the symptoms and complications of pulmonary tuberculosis.
4. Give the symptoms of myelogenous leukemia.
5. Give the complications of familial hemolytic anemia.

PATHOLOGY

1. Discuss briefly the pathogenesis of tularemia and outline its gross and microscopic pathologic anatomy.
2. (a) List the tumors commonly occurring in the pituitary body; (b) List the pathological anatomical lesions that characterize acromegaly.
3. In one sentence, state what you consider to be the special pathological significance of the following: (a) diverticula of the colon. (b) persistence of the ductus arteriosus. (c) syphilitic aortitis localized in the sinuses of Valsalva. (d) retinoblastoma. (e) popliteal arteriovenous fistula. (f) polyposis of the colon. (g) white bile. (h) obstruction of the thoracic duct. (i) Bence-Jones proteinuria. (j) duodenocutaneous fistula.
4. Name two diseases that may be complicated by the occurence of Zenker's hyaline necrosis (degeneration) of skeletal muscle. Describe the microscopic picture of Zenker's necrosis of skeletal muscle.
5. Briefly discuss the occurrence and significance of esophageal varices.
6. Classify in outline form, the leukemias in man. Describe the gross and microscopic feature of the spleen in chronic myelogenous leukemia.
7. Outline the procedure in demonstrating the parasite of the tertian malaria in the blood. Diagram the life cycle of the organism.
8. In outline form, contrast bacillary dysentery and amebic dysentery in respect to (a) etiology; (b) methods of establishing a laboratory diagnosis; (c) preventive measures.
9. Outline the available biological measures for the prophylaxis of five of the following diseases, and indicate the approximate duration of the resulting effective immunity in each instance: (a) small pox, (b) measles, (c) typhus fever, (d) typhoid fever, (e) cholera, (f) yellow fever, (g) diphtheria.
10. Hemorrhagic disease of the newborn and the bleeding that may accompany the jaundice due to cholelithiasis are both the result of vitamin K deficiency, but the mechanisms responsible for the deficiency are different. Wherein lies this difference?

OBSTETRICS AND GYNECOLOGY

1. Describe the placenta as to anatomy, function and pathology.
2. Discuss the etiology and treatment of postpartum hemorrhage.
3. Describe the fetal circulation.
4. Give causes, symptoms and treatment for prolapse of the uterus.
5. How is the face presentation diagnosed and delivered?

SURGERY

1. When does bronchiectasis change from a medical to a surgical problem?
2. What is the physiological basis for the operation of vagotomy in peptic ulcer? Give the advantages and the disadvantages of supra- and infra-diaphragmatic operation.
3. A man, seventy years old, has a large scrotal hernia. What studies should be made to determine the advisability of operation? Discuss the choice of anaesthetics if operation is decided upon.
4. A man is admitted to the emergency ward, unconscious and with a bleeding scalp wound. Discuss principles ((but not details) of diagnosis and treatment.
5. Describe both first aid and hospital treatment of a compound fracture of both bones of the leg.

SPECIALTIES

1. Give cause, symptoms and treatment of acute mastoiditis.
2. Describe and give treatment of scabies; impetigo.
3. Define the following: (a) glaucoma, (b) strabismus, (c) iritis, (d) dacrocystitis, (e) blind spot.
4. What is scurvy? How may it be prevented?
5. Give symptoms and treatment of urticaria.

PREVENTIVE MEDICINE AND HYGIENE

1. Outline, giving essential points to observe, a complete and satisfactory inspection for trailer camps in order that such camps will be safe from a health standpoint.
2. Give a complete program of immunization and vaccination for children from birth up to entrance in school.
3. What is the etiology and what are the measures for control of endemic typhus fever?
4. What are the measures and procedures to be followed in a case of a community food poisoning?
5. Outline necessary program to avoid rickets.

Certificates for Flight Surgeons

Certificates are now ready for mailing to former medical officers who served during the war with the designation as Flight Surgeons.

The certificates, which are suitable for framing, indicate that the officers concerned were graduated from the Aviation Medical Examiner's Course given at the U. S. Air Force School of Aviation Medicine, Randolph Air Force Base, Texas. Those who are eligible to receive the certificates may secure them by writing direct to The Air Surgeon, Headquarters, U. S. Air Force, Washington 25, D. C. Officers now on active duty are not eligible to receive the certificates.

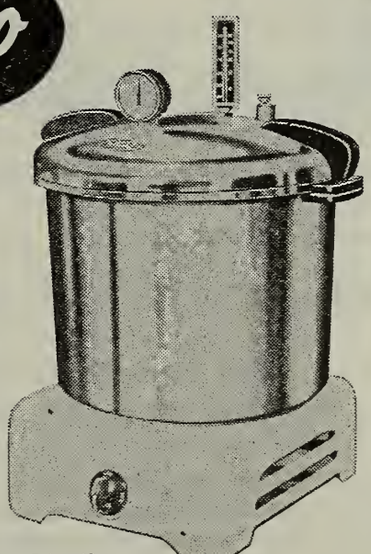
A grant of $8,733 from the American Cancer Society to the University of Cincinnati College of Medicine for a research project on cancer was announced recently.

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Buckeye News Notes . . .

Cincinnati—Dr. Ralph B. Taylor, Columbus, assumed office as president of the National Eclectic Medical Association at the annual convention. President-elect is Dr. R. O. Norris of Tuckerman, Ark.

Cincinnati—Among physicians who attended the reunion of the University of Cincinnati College of Medicine Class of '99 were Dr. Charles Baker, West Milton; Dr. George E. McCulloch, Troy, and Dr. B. F. Metcalfe, Greenville.

Cleveland—Dr. Edward M. Kline has been appointed medical consultant of General Electric's lamp department. He plans to continue his private practice, devoting part of his time to the assignment.

Cleveland—Dr. Harold J. Knapp, city commissioner of health, has been appointed to the Health Museum Board of Trustees.

Columbus—Dr. Robert E. Young discussed "Socialized Medicine" before the Columbus Optimists Club.

Columbus—Dr. Ollie M. Goodloe, Columbus health commissioner, was awarded the 1948 award as the outstanding citizen for public service by the Columbus Junior Chamber of Commerce. Specifically cited by the award were anti-venereal disease and food-handler programs instituted by the department under Dr. Goodloe.

Columbus—Four physicians discussed the importance of health in connection with the annual celebration of National Negro Health Week. They are Dr. H. Sherman Manuel, Dr. Arthur E. Calloway, Dr. Robert M. Manuel and Dr. W. Kenneth Allen.

Dayton—Dr. Mack M. Shafer was elected chairman of the Metropolitan Health Council.

Defiance—Dr. G. Frederick Moench has returned to Ohio as health commissioner of the Defiance County General Health District. Formerly health commissioner in Delaware, Dr. Moench recently has been director of health and welfare at Oak Ridge, Tenn.

Defiance—Dr. Francis M. Lenhart has resigned as Defiance County health commissioner.

Dover—Dr. Elizabeth Rowland-Aplin has been named Tuscarawas County health commissioner.

Grand Rapids—Dr. D. R. Barr has been named a member of the Wood County Park Commission.

Marion—Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, addressed the Rotary Club on the subject, "The Education of Your Doctor."

Nelsonville—Dr. J. L. Wheaton discussed "Socialized Medicine" at a meeting of the Rotary Club.

Perrysburg—Dr. Eugene A. Ockuly, Toledo, spoke on "Socialized Medicine" before the local Exchange Club.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

ADAMS

Members of the Adams County Medical Society held an outing and scientific program at the Serpent Mound Park near Peebles on June 30. A picnic dinner was preceded by a business session at which plans for the proposed hospital for Adams County were discussed. Afternoon speakers were Dr. Ralph W. Eddy and Dr. Clyde M. Dummer of Cincinnati who spoke on the following subjects respectively "Pelvic Relaxation and Displacement" and "Meningococcic Infections."

CLINTON

Regular meeting of the Clinton County Medical Society combined with the Woman's Auxiliary on July 6 for a dinner at the Snow Hill Country Club. Dr. William L. Regan gave a report on the Clinton Memorial Hospital.

HAMILTON

The following officers, delegates and alternate delegates for the Academy of Medicine of Cincinnati were elected for the ensuing year starting in September: Dr. Frank H. Mayfield, president-elect; Dr. Harry R. Mendelsohn, secretary; Dr. Daniel E. Earley, treasurer; Dr. Robert C. Rothenberg, trustee for a three-year term; Dr. William F. Hunting, Dr. Kent E. Martin, Dr. Herman J. Nimitz, Dr. Stanley D. Simon, Dr. John W. Hauser and Dr. Charles H. Moore, delegates for three-year terms; Dr. Charles S. Blase, Dr. J. S. McMath, Dr. J. Edwin Reed, Dr. Herbert J. Brinker and Dr. Daniel C. Rivers, alternate delegates for three-year terms. Dr. J. Stewart Mathews will succeed Dr. David W. Heusinkveld as president of the Academy.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

Members of the Clark County Medical Society held their annual summer party at the Van Dyke Club on the afternoon and evening of June 29. A trap shoot and other outdoor sporting events were held in the afternoon. Dinner was followed by an evening of entertainment.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

CUYAHOGA

New officers of the Cleveland Academy of Medicine are: Dr. Herbert B. Wright, president; Dr. Charles S. Higley, vice-president, and Dr.

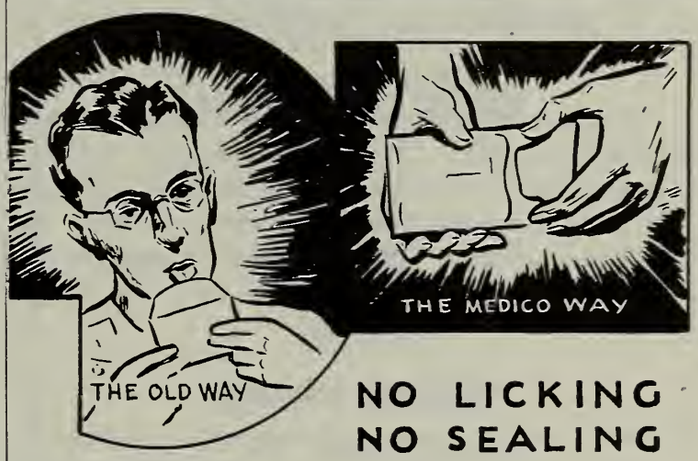
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John D. Osmond, Jr., reelected secretary. The officers were selected by the eight-man board of directors which was elected by the Academy at the May 20 meeting. Members of the board are: Dr. Alexander T. Bunts, Dr. Henry A. Crawford, Dr. J. Stanley Gardner, Dr. William P. Garver, Dr. Joseph M. Hayman, Jr., Dr. Bernard B. Larsen, Dr. Demby M. Spicer and Dr. Wright.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

COLUMBIANA

Dr. John D. Porterfield, Columbus, director of the Ohio Department of Health, was principal speaker at a public meeting at the Lisbon High School on June 21 sponsored by the Columbiana County Medical Society.

PORTAGE

The annual social meeting of the Portage County Medical Society is scheduled to be held on August 10 at Twin Lakes Country Club. The day's events will include golf in the afternoon followed by dinner and an evening of bridge. The following are on the planning committee: Dr. J. R. Turner, Kent; Dr. M. S. Owen, Ravenna; Dr. C. C. Voorhis, Kent; and Dr. R. C. Neely, Jr., Ravenna.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

TUSCARAWAS

Members of the Tuscarawas County Medical Society met July 13 in joint meeting with the Coshocton and Holmes County Medical Societies at the Coshocton Town & Country Club. Dr. George I. Nelson, Columbus, gave a talk on the subject of "Diabetes Mellitus and the Treatment of Its Complications."

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

Approximately 150 persons attended the Eighth District Medical Society meeting at the Rocky Glen Sanatorium in McConnelsville on June 16. Four physicians led discussions in the scientific program which began in the early afternoon.

Dr. L. Chandler Roettig, Ohio State University College of Medicine, Columbus, presented a movie on the "Surgical Procedure of Aortic Resection and Anastomosis on Experimental Animals."

Dr. Bruce C. Martin, also of the O. S. U. College of Medicine spoke on "The Scope of Modern Plastic Surgery."

Dr. Nathan Shapiro, University of Cincinnati College of Medicine, spoke on "Management of Hematemesis and Melena."

Dr. Louis Mark of Rocky Glen Sanatorium



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SURGERY—Intensive Course in Surgical Technique, two weeks, starting Aug. 22, Sept. 26, Oct. 24. Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting Sept. 12, Oct. 10. Surgical Anatomy & Clinical Surgery, two weeks, starting Sept. 26, Oct. 24. Surgery of Colon & Rectum, one week, starting Sept. 12, Oct. 10. Esophageal Surgery, one week, starting Oct. 10. Thoracic Surgery, one week, starting Oct. 3. Breast & Thyroid Surgery, one week, starting Oct. 10. Fractures & Traumatic Surgery, two weeks, starting Oct. 3.

GYNECOLOGY—Intensive Course, two weeks, starting Sept. 26, Oct. 24. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 19, Nov. 7.

OBSTETRICS—Intensive Course, two weeks, starting Sept. 12, Nov. 7.

MEDICINE—Intensive General Course, two weeks, starting Oct. 3. Gastroenterology, two weeks, starting Oct. 24. Gastroscopy, two weeks, starting Sept. 26, Oct. 24. Electrocardiography & Heart Disease, four weeks, starting Sept. 7.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 24. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic & Lecture Course first Monday of every month. Clinical Course third Monday of every month. X-Ray Therapy every two weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 26. Ten-day Practical Course in Cystoscopy every two weeks.

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spoke on the subject, "Pneumoperitoneum in the Treatment of Pulmonary Tuberculosis."

Dr. Mark was honored at the event which marked his 30th anniversary as medical director and president of the sanatorium.

Taking an active part in preparation and presentation of the program were Dr. Chester P. Swett, Lancaster, Eight District Councilor; Dr. Edgar Northrup, Marietta, president of the Eighth District Society; and Dr. Roy M. Meredith, Marietta, secretary of the Society.

FAIRFIELD

"Medical Legislation and Public Relations" was the subject discussed by Mr. George H. Saville, Columbus, public relations director of the Ohio State Medical Association, at the June 14 meeting of the Fairfield County Medical Society in Lancaster.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

SCIOTO

At the July 11 meeting of the Hempstead Academy of Medicine in Portsmouth, Dr. William F. Bradley of Columbus spoke on the subject, "Gastric Ulcer."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

MORROW

Members of the Morrow County Medical Society and the Morrow County Memorial Hospital planning committee met on June 28 with architects to discuss plans for the local hospital.

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
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BUTLER

Hamilton members of the Woman's Auxiliary to the Butler County Medical Society were hostesses on May 24 when the group met for luncheon at Eaton Manor in Hamilton. Highlight of the meeting was the installation of new officers by Mrs. Fred Brosius. Those taking office included: Mrs. W. H. Henry, president; Mrs. Paul Ivins, president-elect; Mrs. John Carter, vice-president; Mrs. William Neel, recording-secretary; Mrs. Jack Harris, corresponding-secretary; Mrs. Robert Wilson, treasurer; and Mrs. A. J. Mackie, director.

The outgoing president, Mrs. Azel Ames of Hamilton, was presented with a gift. Tentative plans were formulated for the coming year. It was announced that there are over 81 members

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in the auxiliary; three new members were introduced at the meeting.

CRAWFORD

The Woman's Auxiliary to the Crawford County Medical Society held its May meeting at the Hotel Weaver. The members were introduced to Miss Lois Stetzer who has been selected for nurses' training under the auspices of the Auxiliary. Miss Stetzer is the second girl to be selected for training since the auxiliary adopted such a program. Mrs. J. W. Arnold, auxiliary president, presided at the meeting. Twelve Bucyrus and Galion members attended.

GREENE

Mrs. H. C. Schick was elected president of the auxiliary to the Greene County Medical Society at its luncheon meeting in May at the Antioch Tea Room at Yellow Springs. Other new officers are: Mrs. Paul D. Espey, president-elect; Mrs. R. D. Hendrickson, secretary; Mrs. Norman Linton, treasurer; Mrs. Lawrence Shields, historian.

Following the luncheon, at which 20 members were present, Mrs. H. C. Messenger, the outgoing president, gave a report of the state convention in Columbus. Later, the group was taken on a tour of the Fels Research Institute. Meetings of the auxiliary will be suspended during the summer months, with activities being resumed in October.

GUERNSEY

Mrs. Gordon Lawyer will serve as president of the Guernsey County Auxiliary, with Mrs. M. S. Lawrence as vice-president and Mrs. O. Reed Jones as president-elect. Mrs. C. A. Craig will serve as secretary and Mrs. J. D. Knapp as treasurer. Officers were named at the May meeting of the Auxiliary at the Berwick hotel. Reports of the state convention at Columbus were given. In June, a picnic meeting was held with the Guernsey County Medical Society.

OTTAWA

The Woman's Auxiliary to the Ottawa County Medical Society won honorable mention for achievement, on the point system, at the Columbus convention, members learned when the group met at the home of Dr. and Mrs. H. O. Beeman for its May session. Mrs. Cyrus Wood and Mrs. G. A. Boon reported on the state convention. Plans were discussed for an open house and picnic June 9 at the Orchard Beach home of Dr. and Mrs. Wood, with Magruder hospital staff members as guests.

TUSCARAWAS

Twenty-one members of the Woman's Auxiliary to the Tuscarawas County Medical Society had a covered-dish dinner at the country home of Mrs. D. H. Downey of Dover. Mrs. W. R. Stager who is moving from Ohio, resigned as president-elect. Following the business session, the group enjoyed an illustrated lecture and demonstration on "Good Grooming" by Mrs. Smythson of Cleveland.

UNION

The Woman's Auxiliary to the Union County Medical Society held its May luncheon meeting at the Dinner Bell. Mrs. A. M. Johnston presided over the business session which included the election of officers. The new slate includes: Mrs. B. E. Ingmire, president; Mrs. E. J. Marsh, president-elect; Mrs. Fred C. Callaway, vice-president; Mrs Walter Burt, secretary. Mrs. Johnston gave a report of the State Auxiliary meeting held in Columbus.

Case-finding aids in all popular media for syphilis control campaigns this summer are being produced and offered for sale on non-profit terms to Federal, State and local agencies by a new organization, the Communication Materials Center of Columbia University Press, it was announced by Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, Federal Security Agency.

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† Wilkerson, H. L. C. and Krall, L. P.. Diabetes in a New England Town, Journal of the American Medical Association, 135:209 (Sept. 27) 1947.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Mr. President, How Is Your Health? by Karl C. Wold, M. D. ($3.00. *Bruce Publishing Company, St. Paul, Minnesota)*, presents a delightful essay on the health and last sickness of each of our presidents, including Mr. Roosevelt. This phase of the biographies of our leaders make fascinating reading. It is a good book for your library—especially your loaning library.

Present Concepts of Rehabilitation in Tuberculosis, by Norvin C. Kiefer, M. D. ($3.50. *Published by the National Tuberculosis Association, New York City)*, presents a review of the literature from 1938-1947 by a physician who left a good practice in Geneva, Ohio, to enter the public health work. The review treats all aspects of the problem including agencies, costs, programs, suitable work, personnel requirements, and psychological aspects. The tenor of the reports on costs are most enlightening and should be put in the minds of most of our citizens, i. e., that the total cost of rehabilitation in the most expensive instances is not as large as one year's support which the taxpayer must contribute if the patient is not rehabilitated. Support is an annually recurring item while rehabilitation costs are paid only once.

Pathology and Surgery of Thyroid Disease, by Joseph L. DeCourcy and Cornelius B. DeCourcy ($10.00 *Charles C. Thomas, Springfield, Illinois)*, presents the experience of long years of work and the management of thousands of cases of thyroid disease at the DeCourcy Clinic and the Good Samaritan Hospital in Cincinnati, Ohio. While the emphasis is on the surgery of the gland, the whole problem of the gland as a site of disease is handled from a much broader viewpoint. Therefore, the book is one that everyone interested in the gland will want.

Poliomyelitis, Papers and Discussions presented at the First International Poliomyelitis Conference ($5.00. *J. B. Lippincott Company, Philadelphia)*. Here we find the various phases of the problem presented by the best authorities. The importance of the disease, its pathogenesis, its management, rehabilitation, bulbar type, immunology and chemotherapy, all are given comprehensive treatment. The work is, therefore, outstanding as a book of reference on this disease which gets so much attention because of its dramatic character.

Hospital Trends and Developments, 1940-1946, edited by Arthur C. Bachmeyer, M. D., and Gerhard Hartman ($5.50. *The Commonwealth Fund, New York City)*. The former superintendent of the Cincinnati General Hospital has brought together some 150 essays on every phase of the modern trend in hospitals which every physician should put on his reading list if he wishes to keep our traditional medicine. More evident than any one other factor has been the move to put sick people in the hospital, sometimes because it is essential, but more often because it is more convenient to and aggrandizing of the physician, or because the patient lives alone or in too small an apartment or house in which to be sick. The social implications of overspecialization and overpopulation for our housing facilities are putting an immense amount of pressure on the practice of medicine. By all means read this book. It is one more that will convince you that we are getting ready to share our poverty (socialism) and that the good old days of the American Republic are gone for several centuries while the race goes back into dark ages—dark ages that this time will be lighted by electricity and not by the Church.

Trends in Medical Education, a Report of the Committee on Medical Education of the New York Academy of Medicine ($3.00. *The Commonwealth Fund, New York City)*, presents ten educators discussing premedical education and the selection of medical students; seven discussions of undergraduate medical education; nine papers on the education of interns and residents; nine on graduate and postgraduate training for specialization; twelve papers on the responsibility of medical schools and hospitals in the education of the general practitioners followed by a very favorable presentation of group practice. In between the lines is much information showing that medicine is following the social pattern of the new age of state capitalism which we entered some four years ago.

Thank God for My Heart Attack, by Charles Yale Harrison ($2.50. *Henry Holt and Company, New York City)*, tells the story of the rehabilitation of one cardiac cripple in a most inspiring manner. Better recommend it to some of your patients as an aid in their rehabilitation.

The Responsiveness of Kindergarten Children to the Behavior of their Fellows, by Esther Kite Harris, being a monograph in the series of the Society for Research in Child Development *(Published by the Society, National Research Council, Washington, D. C.)*, shows that responsiveness seems to be a distinct personality char-

acteristic which varies widely and is not dependent upon age or intelligence; nor is it influenced by group experience. This all adds up to the fact that this characteristic can be guided to help the child conform to the social ways of his fellows.

Geriatric Medicine, The Care of the Aging and the Aged, edited by Edward J. Stieglitz, M. D. ($12.50. Second Edition. *W. B. Saunders Company, Philadelphia)* is a fine record of what is developing in this field. The extension and improvements in this volume over the first edition which appeared in 1943 shows that a good ground work is being laid for geriatrics.

Pharmacologic Principles of Medical Practice, by John C. Krantz, Jr., and C. Jelleff Carr ($10.00. *Williams & Wilkins Company, Baltimore, Maryland).* It embraces what to do and why, how to do it and when. Its central purpose is to present the pharmacodynamic and therapeutic action of drugs.

Fundamentals of Internal Medicine, by W. M. Yater ($12.00. Third Edition. *Appleton-Century-Crofts, Inc., New York City),* has been brought up to date with many changes and additions. The book now has 1,452 pages, covering adequately the entire field. That the authors still stick to their original concept of simplification and conciseness is well illustrated by the fact that Drs. Yater and Grafton Tyler Brown condense all allergy into nine pages—approximately 10 per cent of Medicine into a small fraction of one per cent of the total.

The Child in Health and Disease, by Clifford R. Grulee, M. D., and R. Cannon Eley, M. D., ($12.00. *Williams and Wilkins Company, Baltimore, Maryland),* has been produced because the editors feel that we have come up against a situation that needs correction, i. e., Medical Science has outrun its art and so we find ourselves without sufficient number of physicians trained to take care of our children. This book will go as far as a text can to remedy this situation. The list of contributors is most impressive. Naturally, your reviewer must judge the whole 1,000 pages by the 23 pages devoted to allergy: General Considerations by Bret Ratner, Eczema by Lewis Webb Hill. No more authoritative persons could be found. Good dependable clinical literature, up to date, concise, and to the point.

The New York Academy of Medicine—Its First Hundred Years, by Philip Van Ingen, M. D. ($10.00. *Columbia University Press, New York),* has condensed the story and interpreted the work of this distinguished medical society into 575 pages. Most students of local medical history may be surprised to find that the leaders of this most successful of all local societies in American Medicine, had to lead its membership through many of the same fights that most of the others have fought over. Medical societies seem to have been built out of controversial materials.

Demonstrations of Physical Signs in Clinical Surgery, by Hamilton Bailey ($9.00. Eleventh Edition. *Williams & Wilkins Company, Baltimore, Maryland),* is an excellent aid in teaching from the patient instead of a sheaf of laboratory reports.

Cardiovascular Disease, by Louis H. Sigler, M. D. ($10.00. *Grune & Stratton, New York City),* attempts to do the modern thing, i. e., look up disease as a unit affecting the entire organism even though it may be localized clinically to the heart and blood vessels.

Medicine on the March, by Marguerite Clark ($3.50. *Published for Newsweek by Funk & Wagnalls Company, New York City),* contains attractive material for the education of laymen, well known to readers of *Newsweek.* It can be highly recommended to your intelligent patients, to health educators, and as a reference to writers and radio commentators. It gives these interested persons reliable information from dependable professional sources as a short-cut to more intensive research.

Care of the Surgical Patient, by Jacob Fine, M. D., ($8.00. *W. B. Saunders Company, Philadelphia),* is intended to serve the special purpose of a ready guide for the over-all care of the surgical patient. It epitomizes the essential facts required for an intelligent understanding of surgical diseases, and the basic principles involved in their diagnosis and treatment. It is done from the viewpoint of the patient as a whole being.

Recent Progress in Hormone Research, edited by Gregory Pincus ($7.00. *Academic Press, Inc., New York City),* presents the proceedings of the Laurentian Hormone Conference. The success of the preceding two volumes in previous years will justify your looking into this one. This book has as its objective the critical presentations of problems under active investigation.

Stuttering, by Charles von Riper, Ph. D., prepared for the American Speech and Hearing Association and *distributed by Society for Crippled Children and Adults, 11 S. LaSalle Street, Chicago, Illinois,* for the benefit of the million of our citizens who are afflicted by this most frustrating of handicaps.

Cobalt, by Robert S. Young, Ph. D., A. C. S. Monograph 108 ($5.00. *Reinhold Publishing Corporation, 330 W. 42 St., New York City),* is a comprehensive monograph which deals basically with consideration of cobalt in the relation to anemia in the human being although most of the book is devoted to its role in industry. The changes in the catalytic behavior of cobalt and its biological and biochemical relations are more valuable.



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ANSWER:

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JONATHAN FORMAN, M. D., *Editor*

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Alveolectomy*

KURT TSCHIASSNY, M. D.

TOOTH sockets are called alveoli dentales. Alveolectomy has come to mean surgical removal of the bony structures where those cavities are located. Such metonymies are accepted in the slang of professional terminology. Glottis edema, referring to edematous swelling of the structures surrounding the gap between the vocal cords, called glottis, represents another example.

The main purpose of alveolectomy is eradication of presumed foci of infection, supposedly responsible for systemic diseases. Murray[1] developed a technique for this operation different from the procedure generally used by oral surgeons in this country. His method appears to be particularly influenced by Fischer's[2] beliefs about teeth as pathogenetic factors responsible for focal infections, so well depicted in his book, *Death and Dentistry*. The Fischer-Murray technique has been the subject of discussion and considerable criticism by members of dental and otolaryngological societies in this area.

A recent article by Murray[1] dealing with alveolectomy is the stimulus for this attempt to clarify some of the issues. In the first place the reader of Murray's article might readily obtain the impression that the responsibility for alveolectomy lies exclusively on the shoulders of Fischer and Murray, since the latter has not referred to the history of this surgical procedure.

HISTORICAL REVIEW

Molt[3] has recently reviewed the subject. From him we learn that alveolectomy was performed in the second half of the nineteenth century by Willard (1853) and by Beers (1876). In those days, of course, the only purpose of the procedure was the preparation of the mouth for a permanent set of teeth; as it has been said, "saving nature the task of removing the same matter by absorption." The latter thesis, though unmentioned by Murray, has been reiterated by him as follows, "The surgeon should remove at once what nature will remove anyway."

A factor that contributed to the rise of alveolectomy in the early twentieth century was the promulgation of the theory of focal infection with its rigid demand for thorough removal of potential foci. The establishment of methodical alveolectomy was largely due to the publications of such men as Novitzky, *Notes on Radiographs and the Surgical Treatment of Septic Teeth and Alveolar Process* (1915); Shearer, *External Alveolectomy* (1920); Gardner, *Preparation of the Mouth for the Prosthetist from the Surgical Standpoint* (1923); and Mot, *The Anesthetic and Surgical Problems in Alveolectomy* (1923). The procedure was widely advocated and taught, and articles concerning it originated from all parts of the country. An important principle concerning the technique may be quoted from Molt,

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* Comments on Dr. Maynard Murray's article, "Alveolectomy—Its Indications and Technique," published in *The Ohio State Medical Journal*, December, 1948.

—Reprinted from the Cincinnati Journal of Medicine, 30:299-302, 1949, upon request and with the permission of the author and the Cincinnati Journal of Medicine.

"The proximity of pathologic areas to such vital structures as antrum, palatine foramina, mental foramen and inferior dental canal should be carefully noted *and their invasion avoided.*" (Italics added.)

PRINCIPLES OF MURRAY'S TECHNIQUE IN CONTRAST TO THE GENERALLY USED PROCEDURES

Murray's statements are in considerable contrast to those principles enunciated by others with regard to vital structures. In the more extreme cases, he removes "besides the bony septa between the teeth and the buccal, labial and lingual plates of both jaws, a goodly portion of the hard palate also." He emphasizes, "All bone should be removed regardless of how extensive the operation until a level of good blood supply is reached. The rami should not be left as ivory-like structures but should be cut back until they bleed. That which shows either calcium loss or hypercalcification (increased roentgen density) should be removed. This in the upper jaw may indicate the spread of the dental infection not only into the alveolar processes but into the bony floor of the antrum and through this into the antrum itself." Even though roentgen studies be normal, to Murray "tenderness on deep pressure and/or discoloration of the mouth lining over an alveolar ridge . . ." is evidence for antrum involvement and "calls for surgical removal even when it extends through the bony floor of the antra. If the antral mucous membrane is pathologically involved, it is removed through the operative wound, at times in its entirety. Often we put windows into the nares, if the natural ostia are occluded." (There are two pairs of nares, the anterior ones, called nostrils, and the posterior ones, called choanae. Murray probably means by nares the lateral nasal wall.) *"When penetration into the antrum has shown it to be clean, healing is allowed to occur per primum** (Italics added) . . . there are no contraindications to alveolectomy." He warns against "underoperation even in the seriously ill." "The most serious threat lies not in doing too much but in doing too little."

The fundamental differences between the principles governing the generally used method of conservative alveolectomy versus those on which the radical procedure of Fischer-Murray appears to be based, seemed best illustrated by quoting the writer literally. We are not at present in a position to offer any opinion which one of the two techniques is to be regarded as preferable, the conservative alveolectomy or the method of Fischer-Murray which occasionally represents a sort of "alveolo-antro-uranectomy." Indeed it might be questioned if either of them are justified in any but the rarest occasions in this era of antibiotics and consideration for the whole person. The answer must be left to well-controlled studies.

* The correct spelling is per primam not primum. It means per primam (intentionem) contrary to healing per granulationem, called per secundam (intentionem).

COMMENTS ON PREVIOUS BACTERIOLOGICAL STUDIES

In this connection, comment is indicated on the bacteriological studies previously reported by Murray and Papesch[4] and referred to in Murray's recent article.[1] "It was found in the study of some of 200 cases," where he had performed his alveolo-antral operation, "that the same bacteria were present in the antra as were present in the teeth themselves. Discharges from other sinuses also contained the same bacteria which were found in the teeth." He does not describe the technique used for obtaining material under sterile conditions for his bacteriological studies. It may not be assumed that the criteria of sterile technique are met, by passing into the antrum via an infected alveolus. Likewise, considering the close proximity of the ostia of the maxillary, frontal and anterior ethmoidal cavities in the middle meatus, and of the posterior ethmoidal cells and the sphenoid sinus in the upper meatus and sphenoethmoid recess, it seems rather impossible to obtain separate samples of secretion from the individual sinuses by an endonasal approach.

Murray and O'Ferrell[5] recorded sterile precautions in ten cases by means of an aspiration needle passed into the alveolar recess and in sixteen cases by culturing alveolar bone grindings recovering organisms in every case where "alveolar furriness" was noticed. It seems, however, that these bacteriological findings although interesting are not informative about conditions inside the maxillary cavity. Indeed such an impression is garnered from the writings of Murray[1] himself. He reported instances where the antral mucous membrane after it was perforated through the alveolus, was found to be clean and immediate closure of the operative defect by interrupted sutures was attempted.

FREQUENCY OF ANTRAL SURGERY COMPARED

The number of years required to perform "some 200 cases" of antral operation as reported in 1943[4] is not mentioned. It was thought that it might be revealing to review the number of antral operations performed at the Cincinnati General Hospital between the ten-year period from 1939 to 1948. These data do not include antrum operations performed for purposes such as the taking of biopsies, or of providing approaches for direct irradiation or for facio-maxillary repair. Antrum operations when performed bilaterally in one individual are counted as only one case. Antrum windows performed

as an accompaniment to frontal and/or ethmoidal sinus operations are included.

Year	Caldwell-Luc	Nasal Window	Total
1939	24	7	31
1940	31	1	32
1941	15	9	24
1942	8	4	12
1943	6	3	9
1944	3	2	5
1945	7	7	14
1946	10	0	10
1947	3	1	4
1948	6	2	8

From these figures it becomes evident that the rate of antral surgery at the Cincinnati General Hospital dropped considerably beginning in 1942. While in the first triennium of the decade 1939-1948, the annual average number was 29, for the rest of the ten-year period the annual average number was nine. It is probably not wrong to credit such striking reduction in the use of the knife to recent advances in the use of antibiotics in conservative antiphlogistic therapy. "Some 200 cases" of antral surgery as were reported by Murray and Papesch[4] in 1943, would represent a future activity in antral surgery involving some twenty years at the Cincinnati General Hospital on the basis of present therapeutic principles. Such a calculation, of course, anticipates stabilization at the present rate. However, such standstill appears completely unlikely considering the continuing progress in the field of antibiotics and chemotherapeutics. We are not in a position to offer comparative figures with regard to present alveoloantral surgery at the Murray Foundation. Rumors are of no interest.

These figures may be accepted as illustrating two points. First they reflect strikingly the numerical shrinkage of antral surgery at the Cincinnati General Hospital over the period of the last seven years in comparison with preceding years. Secondly, they illuminate the contrasting difference between principles of indication for antral surgery, as pertain at the Cincinnati General Hospital and those apparently maintained at the Murray Foundation, using as evidence a report which appeared in 1943.[4]

The differences are so great that error in judgment on one or the other side must be postulated. Under the circumstances the open and local problem of focal infection represents a focus of danger which by all means should be tackled at once.

MURRAY'S DIAGNOSTIC AND THERAPEUTIC APPROACH TO THE MAXILLARY ANTRUM

Murray[1] emphasizes the absence of any anesthetic or operative accidents in a rather large series. He does not mention the occurrence of any untoward postoperative sequelae. Probably he has not encountered such experiences since surely he would mention them in such an important issue. However, there is reason to believe that his contact with members of the dental and/or otolaryngological societies in this vicinity could provide him with valuable information in this regard, based on experiences with patients previously operated by Murray.

In this connection a few remarks with regard to the Murray procedures, diagnostic and otherwise, concerning the maxillary antrum should not be omitted. His method of penetration through the antral floor and destruction of healthy antral mucous membrane is intended particularly for diagnostic purposes. According to his description, when "penetration into the antrum has shown it to be clean, here healing is allowed to occur per primum." Such an approach for diagnostic purposes would require a considerable body of evidence to defend it. However, it represents to some extent the approaches as were used for therapeutic purposes by William Cowper (1707) influenced by the studies of Highmore (1657), and Desault (1798) modified later by Kuester (1889).

In modern explorative examination for a questionable maxillary antritis when its existence is suspected by preceding rhinoscopic and/or roentgen and transluminatory findings, we make use of the probatory lavage through the natural ostium, as was introduced by Hartmann (1883), or through the inferior meatus as was first presented by Schmidt (1888) and later modified by Lichtwitz (1890). In my opinion diagnostic lavage preceding alveolectomy, performed in accordance with principles of modern rhinology, will prevent the necessity of destruction of healthy antral mucous membrane, as sometimes unavoidably occurs in the operations by Murray.

Therapeutic methods such as introduced by Cowper and Desault generations ago are of historical interest only. Those procedures are frequently associated with the development of an oroantral fistula, which when it occurs in modern techniques is considered a rare but untoward surgical accident. The deliberate establishment of an oroantral fistula in these times appears to be restricted to the treatment of carcinoma for the purpose of direct irradiation or perhaps in instances of severe gangrenous or necrotizing processes involving the maxilla. In modern rhinology the techniques of those pioneers appears to be replaced by the classical methods of Caldwell (1893) and Luc (1897) with various modifications, and by other more conservative, endonasal procedures.

THE PROBLEM AND HOW IT COULD BE RESOLVED

The purpose of this historical review presented in connection with Murray's recent article

should not be misinterpreted. It is not intended as a polemic based simply on destructive criticism. However, it is well known that there exist fundamental discrepancies between principles of the Fischer-Murray technique on one hand, and those by which generally accepted procedures are directed. It is not anticipated that the latter are the better ones, possibly they may prove to be entirely unjustified in their present form, particularly as concerns focal infection. Or they may be proven to be inferior to the Murray technique by the accumulation of evidence such as those observations and experiences familiar exclusively to Fischer and Murray but so far unknown to the profession.

Clarification of the cloudy atmosphere of this controversy can best be obtained by an amicable and unprejudiced discussion between those interested in the problem. If as the result of an objective exchange of opinion, the Fischer-Murray totalitarian conception concerning surgical treatment of odontogenic focal infection be justified by facts, then it deserves general acceptance by the profession, and adverse criticism will be silenced. No immigration visa need be issued to spirits such as were dominating minds in the days of Galileo Galilei and of Ignaz Philipp Semmelweis. On the other hand when ideas and techniques are proved inadequate or obsolete, then they must be abandoned or modified, in conformation with modern medical advance. In the practice of medicine there do not exist monopolies on the one hand and privileges on the other hand. We are not in business; in the practice of medicine, technical methods must be strictly subject to the art of medicine. Progress in our profession as elsewhere is based on the continuing replacement of the good by the better.

Physicians regard it to be their duty as practitioners and teachers to provide besides professional care, an unlimited appreciation of scientific sincerity. There are three ideas difficult of expression by novices as well as by professors in our field. The three in the order of their difficulty of pronunciation are: (1) "I do not know," (2) "I am wrong," and (3) "You are right."

Adverse opinions in certain professional matters have been traditional among physicians, and in medical history frequently they have represented the cause of acrimonious controversy. It seems to have been so in the days of Claudius Galenus who is credited with the dictum: "Medicus medicum odit" (The doctor hates the doctor). Modernly, such professional diversities are to be resolved judiciously even at the price of personal feelings on the part of one or the other party; the benefit of our patients occupies the primary position in relation to anything else. The goal of controversial discussions among doctors has to be: Save the patient even when you must sacrifice face, but—for heaven's sake—not the other way round. In such spirit the result of a conference as suggested will no doubt prosper both the advancement of information and the welfare of those depending on our medical care. No participant should fear the truth even when it contradicts his previous conceptions. Photophobia does not afflict the eyes of science.

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Outline for Management of Tetanus Patients

1. Combat toxin present.
   a. 50,000 units antitetanus serum intravenously stat and 20,000 units intravenously or intramuscularly each succeeding day.
   b. Methenamine gr. XV intravenously two hours after intravenous dose and from ten to twelve hours, after intramuscular dose.
2. Combat toxin production.
   a. Immediate excision of local lesions where possible.
   b. Culture douche for infected abortions.
   c. $KMNO_4$ packs to wound. Infiltration with 10.000 units antitetanus serum through tissues adjacent to wound at time of excision.
3. Combat convulsions.
   a. From 20 to 40 cc. paraldehyde, orally or rectally pro re nata.
   b. Intravenous administration when necessary.
4. Combat and prevent complications.
   a. Protect patient with side canvas or net.
   b. Administer penicillin.
   c. Give CO_2-O_2 mixture for one minute every two hours.
   d. Continuous O_2.
   e. Observe closely for stridor and keep tracheotomy set at the bedside for use if needed.

Do not give antitetanus serum intrathecally.

Do not ignore "healed" or " nearly healed" lesions.

Do not use barbiturates, ether, curare or phenol.
—Cyril Costello, M. D., St. Louis; Jour. of Missouri State Med. Assn., Vol. 46, No. 8, August, 1949.

Plastic Surgery—Four Case Reports

SAMUEL SELTZ, M. D.

CARCINOMA of the nose and areas about the face require wide excision for proper cure. Usually quite extensive deformity is left and plastic reconstruction is necessary. It is much more important to be sure that thorough removal of the new growth is done than to worry about the resulting defect, for if the patient gets a recurrence there will be no defect to cover. If the defects are small, they can be closed by immediate suturing; larger ones will require flaps and free grafts. These patients become social problems and proper correction is necessary for rehabilitation. The congenital defects, as well as the acquired, should be corrected. Among the latter are nasal deformities, unusual ear deformities and chin deformities. I am reporting four cases with illustrations.

The Author

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CASE REPORTS

Case 1: This is a 65-year old male, seen in the Cancer Clinic of the Jewish Hospital who had had a sore and ulcerating nose for about 15 years. He had been to many doctors and was treated with salves, electric machines, X-ray and inadequate surgery. He had a small skin graft placed about three years before admission. This had begun to shrivel and ulcerate along with the lower lateral cartilage at the junction of the columella and ala on the left side. Biopsy of this area revealed basal cell carcinoma. It was decided to remove the entire tip of the nose up to the caudal end of the nasal bones. On July 20, 1947, under pentothal sodium, with the Bove knife, the tip of the nose was removed including the entire columella.

On September 23, 1947, with the nose completely healed, under local anesthesia, an incision was made across the root of the nose at the glabellar level. The skin over the root of the nose was dissected free down to the caudal edge of the nasal bones. The edges of the nasal defect were freshened, and the above turned down flap sewed to the skin edges of

Read at a meeting of the Cincinnati Otolaryngology Society, January, 1948; and submitted for publication December 23, 1948.

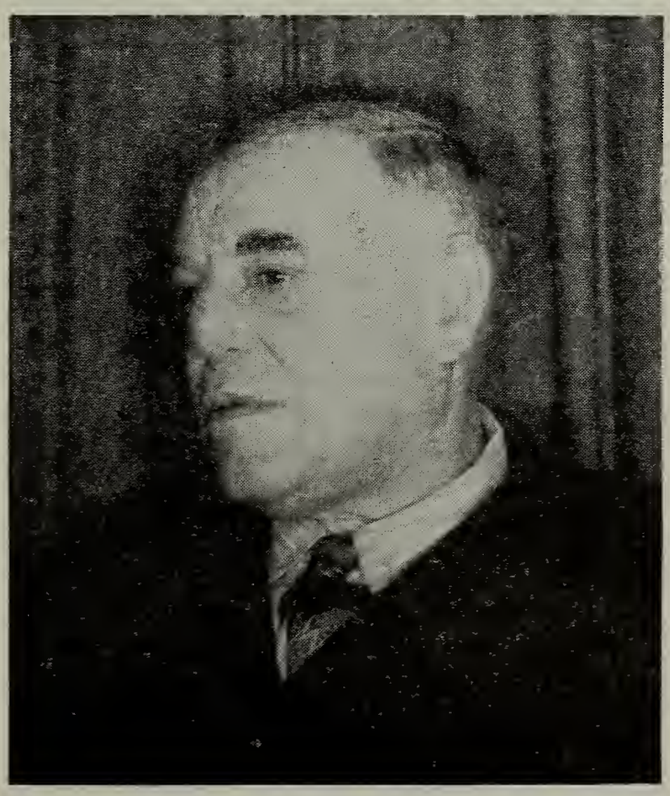


Figure 1. Case 1.



Figure 2. Case 2.

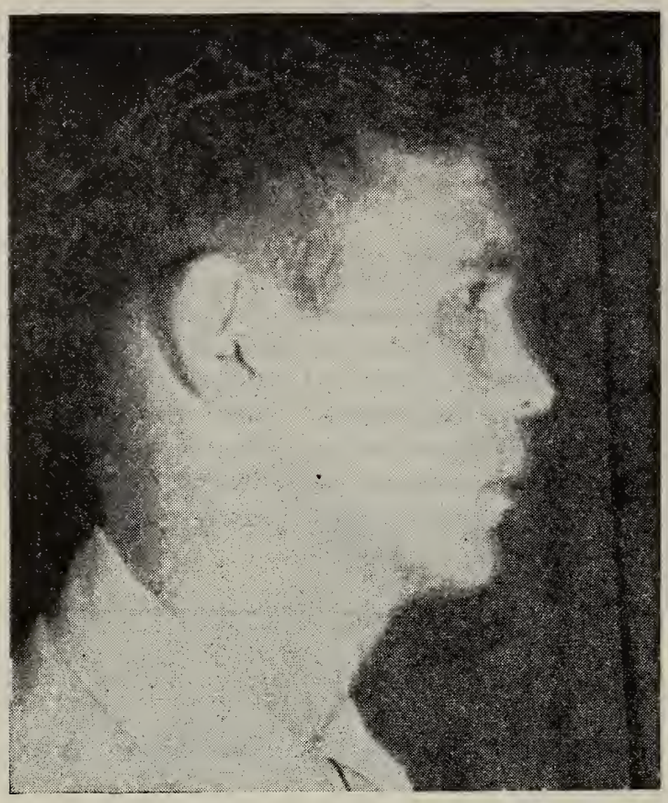


Figure 3. Case 3.



Figure 4. Case 4.

the defect, thus providing a lining for the nose. A large flap to cover the entire nose and columella was then outlined on the forehead, dissected up, and resutured in place for about four days. On September 27, 1947, the forehead flap was dissected up again and sutured to the edges of the nasal and columellar defect. On October 7, 1947, the flap was cut free of its attachment to the forehead. The forehead defect was closed with silk sutures as far as was possible, leaving a small defect. This closed by primary intention. Patient left hospital on October 20, 1948. See Figure 1 as of December, 1948.

* * *

Case 2. White female, aged 25, with congenital long and humped nose. Rhinoplasty done under local with removal of hump, narrowing of bridge, shortening of nose with narrowing of alae. See Figure 2.

* * *

Case 3: White male, 20 years old, was in auto accident with resulting crushing of nasal bridge (saddle nose). Under local anesthesia, piece of pickled cartilage was placed over dorsum, by way of the left limen vestibula. See Figure 3.

* * *

Case 4: White girl, 10 years old, with congenital lop ears. She was very conscious of the prominent ears and her playmates did not help her. Under general anaesthesia the ears were placed in their proper places. See Figure 4.

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The Problem of Plantar Radiodermatitis

Radiodermatitis is usually a difficult problem to handle, not only because of the disability entailed but also because it is considered by many as a precancerous dermatosis. Except in the case of postoperative irradiation at the site of malignancies, there is no excuse for plantar radiodermatitis. Common corns, neurovascular corns, and mosaic warts are known to be radioresistant. Radiotherapy is definitely ineffective on calluses so they should never be treated by this method. Yet, all dermatologists have had patients with some type of radiodermatitis caused by someone's carelessness or the persistent use of roentgen, radium, or Grenz rays. Usually, these cases are the result of inadequate shielding, intensive dosage, prolonged treatment, and poor judgment in the choice of therapy.

Radiodermatitis anywhere on the body is difficult to treat, but it is particularly difficult on the plantar surface of the foot because of the weight-bearing function of the foot.

Most cases of plantar radiodermatitis are the result of treatment for corns, calluses, and warts. Because of these original lesions, plantar radiodermatitis usually occurs over bony prominences. Even after the original lesion has disappeared, pain still persists because of the pressure of the underlying bony points on the fibrotic radiodermatitis.—A. H., R. M., and D. C. Montgomery, N. Y. C., N. Y. State Jour. of Medicine, Vol. 49, No. 14, July 15, 1949.

The Laboratory and Clinical Evaluation of a New Antacid Preparation*

ETHAN ALLAN BROWN, M. D.

THE theoretical causes of indigestion are many, and among others, the following as listed by Ivy[9] must be considered: (1) The acid-peptic; (2) the vascular, as due to spasm or tugging of the vessels; (3) the gastric, as caused mechanically by rough, irritating foods, chemically by acid, and bacteriologically by nonspecific inflammation or specific streptococcal infection; (4) the neurogenic, as seen in vascular spasm, hypermotility and hypersecretion; (5) the allergenic; (6) the nutritional; and (7) the unproven constitutional factors, as metabolic or endocrine disturbances. As seen in peptic ulcer, for which the causes are almost identical, the presence of excess free acid, the excessive sensitivity of the inflammed gastric mucosa to its presence, and ultimately its lost ability to resist the digestive action of the acid pepsin secretion, all play their part as do the emotional and psychosomatic causes. Emery[4] suggests that for ulcer patients, nervous and emotional tension are the most frequently activating influences. Eusterman[5] and Alvarez[1] have emphasized the great part played by psychosomatic factors.

Whatever the cause, the condition is usually chronic and whether the treatment be medical for mild, occasional symptoms, or surgical for the patient who may have progressed to recalcitrant ulceration, the relief of the typical dull, aching, gnawing, hyperpyrosis is demanded by the patient, who, however stoical, can neither ignore its presence nor endure its persistence.

GENERAL MEDICAL TREATMENT

General medical treatment includes the elimination of physical and mental fatigue by adequate rest, and if necessary, sedation; and, in addition, the diminution or proscription of secretagogue substances as spices, coffee, alcohol, tobacco, and coarse foods. The general gastric medications, belladonna and phenobarbital, are often prescribed. For immediate, specific effects, antacid therapy is essential since it controls not only the hyperacidity, but also the hypersecretion, the hypermotility, and most important, the discomfort and its secondary emotional sequelae. Of the 159 studies reported to the Survey Committee of the American Gastroenterological Association, Sandweiss and Gutterman[16] reported 23 per cent as dealing with the standard treatment with bland diet, antacids, and antispasmodics.

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SPECIFIC ANTACID TREATMENT

Parson[14] has grouped the available antacids into four classes. Since soluble antacids, as sodium bicarbonate, are absorbable, they may cause alkalosis and urolithiasis. Gastric rebound after the immediate neutralization causes eventual exacerbation of the condition treated. Tribasic calcium and magnesium phosphates, which are neutral antacids, are not absorbable and have therefore long-lasting effects. They do not, however, cause the immediate relief of symptoms demanded by the patient. The aluminum compounds are astringent and demulcent as well as efficient, but are constipating unless occasional doses are combined with magnesium oxide or carbonate and also do not offer the prompt relief desired. The fourth group consists of magnesium trisilicate generally available in combination with aluminum hydroxide and purified mucin. Despite these many types of antacids, Lesser[11] quotes Travell[15] as saying that "calcium carbonate has probably proved to be the most effective single antacid." In combination with magnesium oxide, it is used by Weintraub[18] and combined with bismuth subnitrate by Driscoll and Aaron.[3]

AMINO ACID TREATMENT

In 1942, Siler and Levy[17] demonstrated the buffer action of oral amino acid therapy for the treatment of hyperacidity as seen in ulcers. More recently, in 1944, Co Tui[2] has worked with the amino acids. Since these are biologically derived

and natural to the body as well as amphoteric in their reaction to gastric acidity, they "not only neutralize the acid and relieve the stomach of digestive effort, but furnish the body as well with a rich source of nutriment with which body repair, including the healing of the ulcer, can take place." The efficacy of amino acids has been evaluated by many investigators including Hodges,[8] Kimble,[10] Margaretten,[13] Vinci,[19] Ruggiero[15] and Levy.[12]

There is no question that among the natural products that have been used as antacids, milk stands out as having survived the test of many decades of therapeutic usefulness. Thus in 1829 Cruveilhier recommended a milk diet for the treatment of ulcer. The diet advocated by Sippy in 1915 recognized the value of the acid neutralizing qualities of milk, and involved the use of milk and cream hourly, 12 hours daily, often combined with alkali. Eyerly and Breuhaus[6] have also pointed out that "milk is one of the oldest and closest to the ideal (antacid) that we have, yet its sole use in the amounts required is impractical." Although many antacids have been introduced to the medical profession, none has ever been presented which is equivalent in buffering capacity to therapeutic doses of milk.

The search was therefore made for a suitable chemical antacid which would behave similarly to milk in possessing immediate and prolonged antacid action. Such a preparation also had to possess certain other advantages inherent in milk and considered desirable properties for an ideal antacid as set forth, for example, by Goodman and Gilman.[7] Like milk, this preparation must avoid causing systemic alkalosis and acid rebound, it must maintain the pH of the stomach contents within the range for optimal digestion, and should not absorb enzymes necessary to the normal digestive processes. Needless to say, the preparation should be nontoxic even in excessive doses or with use over an extended period of time. Furthermore, to avoid the disadvantages of milk, it should be convenient to take, free from allergic manifestations, and have a minimal caloric value.

IDEAL ANTACID TREATMENT

The search for a preparation possessing the desirable antacid properties of milk, as discussed above, revealed that two separate concomitant actions were required, namely, immediate neutralization and prolonged buffering effect. Experimentation with numerous neutralizing and buffering agents finally led to the selection of glycine (glycocol or amino acetic acid) and calcium carbonate, the buffering and neutralizing agents respectively.

Further study indicated that the specific proportion of three parts buffering agent (glycine) to seven parts neutralizing agent (calcium carbonate furnished a substance whose antacid titration curve closely paralleled that of fresh milk. Though both of these substances have long been recognized to have antacid properties in their own right, neither one alone possesses this desirable characteristic. However, by suitably combining the two in the particular proportion stated, it was possible to achieve, through the interdependent action of each, the sought after antacid preparation. It is now available under the name "Titralac."

Table I

Time Neutralization Tests on Milk, "Titralac" and Alumina Type Antacid
Effect on 50 cc. of N/10 HCl

Contact Time Min.	Milk 100 ml	Milk 250 ml	"Titralac" (0.5 Gm)	Alumina Type Antacid (0.5 Gm)
1	4.50	5.56	4.85	1.55
6	4.50	5.62		
12	4.50	5.64	5.55	3.40
18	4.50	5.66		
24	4.50	5.66		
30	4.50	5.68	5.65	3.65
36	4.50	5.71		
42	4.50	5.71		
48	4.50	5.70		
54	4.50	5.71		
60	4.50	5.71	5.85	3.73

Table I shows the variation of pH with time during neutralization tests on milk, "Titralac," and an alumina type antacid. The figures disclose that within one minute 0.5 gram of "Titralac" provides the antacid affect of 100 cc. of milk, and within 12 minutes, the antacid effect equaled 250 cc. (8 oz.) of milk.

CLINICAL RESULTS

In all, 110 patients who presented the usual picture of postprandial pyrosis following the ingestion of certain types of food especially those known to cause gastric distress, were studied clinically. The foods listed were fatty mixtures, such as mayonnaise, fried onions, doughnuts, fried chicken, frankfurters, pork sausage, and cake, as well as irritating products such as spices, garlic, cabbage, and highly flavored vegetables. The majority of patients were being studied for their atopic conditions, the indigestion being a concomitant complaint. In three patients, peptic ulcers, confirmed by gastrointestinal studies, were present, four were clinically sensitive to milk, seven were following reduction diets.

All of the patients presented a typical history in that sodium bicarbonate and other rapidly acting antacid substances caused immediate relief. In many cases relief of gastric distress was associated with the necessity of taking increasingly greater amounts of medication, which tended to produce either diarrhea (with the

magnesium compounds), or constipation (with the aluminum hydroxide). In all, without exception, the use of "Titralac" was reported as being more effective than anything previously used for the same complaints, with an immediate relief which was striking, and a duration of relief worthy of note. In no single case was there diarrhea or constipation or any necessity for increasing the medication over the period of time the patient was studied. Since the majority presented hay fever and allergic complaints requiring treatment at frequent intervals, it is specifically a part of their notes that none have returned to the use of any other antacid medication. In addition, the "Titralac" was used successfully for long periods of time in two cases of nausea of pregnancy in which ordinary alkali therapy had completely failed. One of these presented typical pregnancy toxemia.

CASE REPORT

Of the patients with peptic ulcer, the following history, typical of others, is chosen.

Case 1. G. C., male, aged 42. The patient was hospitalized March 11, 1944, for treatment of abdominal distress, remaining under treatment for some months. For the previous three years there had been attacks of epigastric pain and vague abdominal distress. Two weeks prior to hospitalization, nausea, vomiting, and epigastric pain had been present approximately one hour postprandially.

The physical examination was essentially negative. The examination of the abdomen revealed no masses or tenderness, the gastro-intestinal series, however, definitely proved the presence of an active duodenal ulcer, still present on re-examination on April 23, 1945. The response to medical treatment with other antacid treatment was fair.

On December 20, 1945, the treatment with "Titralac" was initiated, 0.5 gram and 1.0 gram doses being given after each meal, with one dose at bedtime as well as during the night if and when distress occurred. On January 3, 1946, the patient reported that he had no recurrence of pains since taking the antacid material four times daily. He has been seen at intervals from December 20, 1946, to March 22, 1948, during which time he had presented no symptoms whatsoever, X-ray studies having confirmed the complete healing of the ulcer, present on previous examination. No present treatment is being given excepting for occasional postprandial distress following the ingestion of the interdicted foods. Excepting for mild diet limitations, the patient is receiving no other treatment.

SUMMARY

A new antacid preparation which parallels the neutralizing and buffering action of milk is discussed.

From 110 patients so far studied, and including all gradations of indigestion from mild postprandial pyrosis to severe pain associated with ulceration, it can be concluded that the action of the antacid preparation is prompt and prolonged.

This antacid causes neither diarrhea nor constipation, and neither acid "rebound" nor systemic alkalosis. It is evidently non-toxic even when taken in excessive doses and is suitable for use over extended periods of time.

Although free of the caloric values of milk, this preparation seems to act as the equivalent of milk in antacid effect and is free from allergic manifestations.

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Obstetric Interference

In obstetric practice the physician is charged with the conduct of the most vital of all human functions: reproduction. He is held responsible for the safety of not one, but two lives. Hence the emotions of the patient and her family are aroused to a pitch seldom encountered elsewhere in the practice of medicine. The physician's judgment is in constant danger of being deflected by these recurrent emotional blasts. Therefore, he must make for himself a fundamental decision: Are the patients to be treated according to the precepts of the best current obstetric thought, or are their fears, fads, and fancies to be allowed to influence treatment? Putting it bluntly, are they to be treated as they should be treated or as they want to be treated?—Chester D. Bradley, M. D., Newport News, Va.; N. C. Medical Journal, Vol. 10, No. 7, July, 1949.

Tumors of the Nasopharynx

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THE subject of tumors is now so effectively presented to the public that "tumor consciousness" is almost assuming for a certain type of patient the proportions of a psychosis. Granting that this is so the price is not too high to pay for the practical benefits of early diagnosis and increased chances of cure. Similar propaganda among physicians may also be justified for like reasons. New,[1] Cantril and Buschke,[2] as well as other writers on this subject point the finger of blame at all of us for our carelessness, neglect and all too frequent ignorance in dealing with this clinical entity of tumors of the nasopharynx.

It is not intended that this paper should be exhaustive in itemizing all neoplasms of the nasopharynx and portraying their pathologic and clinical characteristics. Nor is it proposed to enter into the polemics of histologic classification. It is quite sufficient, and I hope worth while, to briefly survey the list of common neoplasms of the nasopharynx and call attention to well known but easily forgotten points in their diagnosis, clinical course and treatment. Use will be made of clinical and laboratory material of St. Luke's Hospital with which I am connected.

INCIDENCE OF NEOPLASM

In the preparation of this paper I surveyed the clinical and pathology records of the hospital for the past ten-year period. This search revealed the reports of 13 cases of neoplasm of the nasopharynx proper. Of these 13 cases 7 were malignancies. During this interval St. Luke's Hospital admitted a total of 137,529 patients. Thus the incidence of nasopharyngeal neoplasm at our hospital is approximately one case to every 10,000 admissions.

UNRELIABILITY OF STATISTICS

At this point it is appropriate to point out, as has Hayes Martin, that statistics relating to tumors of the nasopharynx are not too trustworthy since much liberty has been taken with the anatomic locale termed the nasopharynx. For example Titrud and Peyton[3] in a very good paper, report on a series of 195 cases of malignancy of the nasopharynx. These authors frankly specify that these tumors arose in an area extending from the base of the tongue to the vault of the true nasopharynx. This of course is a too generous interpretation of the anatomic nasopharynx, which is bounded inferiorly by the lower border of the soft palate. It, therefore, is quite evident that not all of these 195 neoplasms were necessarily located in the anatomic nasopharynx although the title of their paper would indicate this. Another source of statistical error are tumors originating in the nose or sinuses but which have prolongations that secondarily invade the nasopharynx.

Of the benign neoplasms of the nasopharynx otolaryngologists probably are more often confronted and therefore most interested in fibroma. Eggston and Wolff[4] describe the various types of fibroma encountered in otolaryngology. One type is the benign tumor of fibrous connective tissue not infrequently found in the mouth, pharynx or larynx. This tumor may be of any size and of any consistency depending on the preponderance of fibrillar or collagenous connective tissue.

JUVENILE TYPE FIBROMA

However, the second type of fibroma, the so-called juvenile type, although fortunately rather rare is one that often challenges the surgical skill and commands the special interest of the otolaryngologist. Characteristically this tumor occurs most often in young males from 10 to 25 years of age. The most frequent site of origin is the periosteum of the posterior osseus walls of the nasopharynx where the tumor has a more or less sessile attachment. A possible explanation of this singular tumor is its formation as the result of unequal development of the cranial bones during fetal life. As such a subject approaches puberty when bone growth accelerates, this congenital defect in the periosteum results in connective tissue hypertrophy instead of normal bone growth.

Although the juvenile fibroma is pathologically benign it may menace life through its erosive

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tendency on adjacent structures. Thus may result serious hemorrhage or even meningitis. Clinically it is firm even to hardness while histologically the stroma consists largely of very dense collagenous connective tissue. Intermingled in the stroma may be glands and certainly numerous arteries and veins. This vascularity seriously complicates the surgical removal of these tumors and when the tumor is ulcerated and secondarily infected accounts for the episodes of bleeding that often distinguish this tumor.

Symptoms other than bleeding that may indicate the presence of the tumor are interference with nasal breathing, change in the resonance of the voice, hearing difficulty from tubal blockage, an adenoid facies and mental dullness. Should the tumor grow sufficiently there may be pain of trigeminal origin and dysphagia from interference with the soft palate.

As stated previously the adequate treatment of this new growth is often a real test of the surgical skill and fortitude of the otolaryngologist. This test becomes increasingly significant the larger the tumor, the richer its vascularity and the more extensive its invasion of the sinuses or orbit or cranial cavity itself. The clinical observation that these tumors may spontaneously regress after a period of years is not sufficient to justify a hands off-do nothing policy. The use of roentgen and radium irradiation alone is probably inadequate to cause total disappearance of the tumor as emphasized by Hauser.[5] However, preliminary irradiation may so lessen tumor bulk and vascularity as to facilitate subsequent surgical removal. Preliminary to surgical excision carotid ligation and section of the soft palate together with possible removal of the posterior bony hard palate may be advisable and necessary. In certain cases of extension into the orbit or sinuses transantral or fronto-ethmoid sinusotomy may be indicated. Electro-coagulation is a distinct aid in controlling bleeding and in destroying tumor extensions not otherwise accessible.

The following case is illustrative of the symptomatology and treatment of juvenile fibroma of the nasopharynx.

ILLUSTRATIVE CASE REPORT

L. Z., a boy aged 17 years, was admitted to St. Luke's Hospital March 23, 1936, on the service of Dr. J. W. McCall. His complaint was increasing nasal blockage for the previous eight months with occasional bloody discharge from the mouth and some swelling of the left cheek. Clinical examination revealed a large firm mass filling the nasopharynx. Removal of the mass was accomplished under avertin anesthesia.

The soft palate was sectioned, a nasal snare was manipulated into position about the tumor base and the tumor removed by passing a coagulating current through the snare wire. It then became evident that the tumor had invaded the left antrum. Accordingly two weeks later the left antrum was exposed and it was seen that the fibroma had eroded the posterior part of the naso-antral wall and extended laterally into the left cheek having eroded the zygomatic recess. It was removed with difficulty by sharp and blunt dissection. The severe bleeding was controlled by hot packs and electro-coagulation. A transfusion of whole blood was given postoperatively.

OTHER BENIGN NEOPLASMS

Of other benign neoplasms of the nasopharynx may be mentioned hemangioma, neurofibroma, lipoma, dermoid, chondroma, teratoma, chordoma and mixed tumors as well as cystic and polypoid tumors. Irradiation is usually effective in treating hemangioma although surgery may be necessary. Neurofibroma and mixed tumors are usually so well encapsulated that surgical removal is the treatment of choice. Foster[6] has recently reported a small pedunculated dermoid of the nasopharynx. This was present in a 19-day old infant and was readily removed by snare. The tumor contained sebaceous and sweat glands, hair follicles, fat, cartilage and nerve fibres. An 11-month old female infant was recently admitted to St. Luke's Hospital on the service of Dr. D. M. Glover with the findings of cleft palate and a large tumor in the left side of the nasopharynx. At postmortem examination the tumor proved to be a teratoma. At St. Luke's in the last ten-year period we have not seen an example of chordoma of the nasopharynx. These interesting tumors are derived from the embryologic notochord and may simulate malignancy.

Of cystic and polypoid tumors all otolaryngologists are familiar with the choanal polyp. Whether recent or old the usual attachment is in the middle meatus of the nose with the tumor dangling in the nasopharynx from a pedicle. When present for some time these polypoid tumors become quite fibrous, firm, large and often ulcerated giving a first impression of fibroma or other tumor until thorough examination reveals the pedicle and their true identity as choanal polypi. A case typical of such a tumor is the following.

ILLUSTRATIVE CASE REPORT

S. B., a boy aged 7½ years, had experienced increasingly difficult nasal breathing for the last year associated with much bilateral nasal discharge. There had been no bleeding. Examination revealed a large, firm, slightly movable, rounded, pinkish tumor filling the nasopharynx. There was no associated adenopathy. The inferior border of the tumor was ulcerated and was readily visible below the soft palate when the patient gagged. The patient was admitted to my service at St. Luke's Hospital where biopsy and later removal of the tumor was accomplished. The biopsy report was "poorly cellular fibroma of nasopharynx, adult type."

At operation the elongated pedicle with its

attachment in the left middle meatus indicated that the tumor was a choanal polyp of long duration which had undergone fibrosis. This opinion was substantiated by two recurrences at which the tumor was definitely a typical choanal polyp. The recurrences followed avulsion technic but there has been no return since amputation of the pedicle with the coagulating current.

EXAMINATION OF NASOPHARYNX

I have just used the term "thorough examination" and it is opportune here to say a few words concerning what is meant by this expression. Categorically one may state that any procedure is thorough that permits complete visual and/or tactile exploration of the entire anatomic nasopharynx. Very often no one procedure is adequate but several must be used. Such procedures include posterior rhinoscopy with a mirror, the use of a Yankauer direct speculum, elevation of the soft palate with rubber catheters passed through the nose as recommended by Beck years ago, the electric nasopharyngoscope introduced through the nose or through the mouth, direct digital examination, anterior rhinoscopy through a nasal speculum after thoroughly shrinking the turbinates and finally by roentgenography. The taking of biopsy specimens should be a routine.

TYPES OF EPITHELIUM

We come now to a consideration of malignant neoplasms of the nasopharynx.

As an introduction to this subject it is essential to recall the varying types of epithelium encountered in this area such as pseudostratified ciliated with numerous goblet cells seen in the vault while more inferiorly is found the transitional stratified columnar form with the stratified squamous variety still more inferiorly and extending on into the oropharynx. In addition the presence in the epithelial covering of the nasopharynx of salivary gland elements adds still another source of neoplastic tissue.

As a result of this diversity of tissue types there is found a wide variety of malignant growth in this sharply circumscribed area including the various types of epidermoid carcinoma, certain malignant tumors of the salivary type, the adenocarcinoma and tumors of lymphoid origin as lymphosarcoma. Although Regaud and Schminke allegedly first used the term lympho-epithelioma to describe certain highly undifferentiated forms of epidermoid cancer Hauser and Brownell[7] deplore this terminology asserting that the so-called lympho-epithelioma and transitional cell tumors are varying forms of medullary squamous cell carcinoma and should be classified as such.

NASOPHARYNGEAL LYMPHATICS

Along with the review of the tissue components of the covering membrane of the nasopharynx should be added a word concerning the lymphatics of the nasopharynx. The collecting lympatic vessels from the adenoid area largely terminate in the median and lateral retropharyngeal nodes as well as the upper nodes of the spinal accessory chain which lie under the upper end of the sternomastoid muscle below the tip of the mastoid.

Additional minor lymphatic connections must favor easy metastasis from the cervical lymphatic system to lymph nodes in the middle and lower portions of the neck. However accurately traced and identified the early and marked metastasis to the lateral neck regions testifies to the richness and complexity of this lymphatic network.

FACTS ABOUT NASOPHARYNGEAL CANCER

Passing on to the clinical facts pertaining to malignancy originating in the nasopharynx, it makes a sorry tale. This pessimism stems from two sources. One is diagnosis and the other is treatment.

Certain well known facts about cancer of the nasopharynx may be briefly stated. Though not the most frequent it is one of the most malignant growths of the upper respiratory and alimentary tracts. It constitutes about 2 per cent of all malignancies of the head and neck regions. It is predominantly a disease of the male about 80 per cent of the cases occurring in that sex. More than 50 per cent of the cases occur between the ages of 40 and 60 years. Cancer of the nasopharynx is found more often in children and below the age of 30 years than any other malignant growth of the upper respiratory or alimentary tracts. In about 50 per cent of the cases the first and only complaint is cervical metastasis which usually first appears just below the mastoid tip.

ERRORS IN DIAGNOSIS

As regards the diagnosis of cancer of the nasopharynx it is probably true that in no other form of malignancy is the diagnosis made so tardily or so erroneously. All too often these unfortunate patients are doubly crucified by having cancerous glands poulticed or treated with penicillin, teeth extracted, tonsils removed, sinuses opened, ear drums incised or septum straightened because of tragic misinterpretation of symptoms. Hauser and Brownell estimate that in their series of patients 32 per cent had some form of needless surgery before the correct diagnosis was established. It is also regrettable that on the average about a year elapses before the true condition is recognized. This deplorable record is largely due to two chief causes.

One reason is the relative unimportance of the nasopharynx from the standpoint of disease with the two exceptions of neoplasms and diseased adenoids with the associated ear symptoms. Because of this fact together with the difficulty of

examination, the nasopharynx is a part of the anatomy that is universally neglected in most examinations. The second reason is the well established fact that only in about one-half of the cases of malignancy of the nasopharynx are there any local symptoms that call attention to the primary lesion. In consequence of these facts we otolaryngologists by precept and example should spread the gospel of more and better examinations of the nasopharynx. For the sake of emphasis may I repeat the phrase of "more and better examinations of the nasopharynx."

SYMPTOMS OF CANCER

For over twenty-five years there has developed a literature replete with case reports and statistics portraying the characteristics of nasopharyngeal malignancy. I have no new signs or symptoms to add but wish merely to recall and emphasize some of the more important ones. I would first call attention to metastatic adenopathy since this is the symptom that first brings the patient to the doctor in fully 50 per cent of the cases.

Early metastasis is usually with nasopharyngeal malignancy especially with the lymphosarcoma group and here the glands are apt to be larger than in the squamous cell type. While unilateral metastasis ordinarily appears first its presence bilaterally is the rule in all advanced cases. As would be expected the presence of a mass in the nasopharynx would cause a variety of symptoms due to simple obstruction ranging from a change in the resonance of the voice, increasing mouth breathing and rhinorrhea to the effects of tubal blockage as fulness and ringing in the ear and diminished hearing. When ulceration occurs there is the added feature of bloody nasal discharge or postnasal drip.

CRANIAL NERVE INVOLVEMENT

Certainly the most spectacular symptom results from the pressure on nerves. Since the neoplasms arise from the region of the fossa of Rosenmüller as well as the usual adenoid bearing area there is free access to the adjacent sixth cranial nerve through the foramen lacerum. Intracranial invasion also occurs by other adjacent foramina as well as by direct invasion through the eroded cranial wall which in this area is rather thin. The net result is possible involvement of any of the cranial nerves or the Gasserian ganglion although the fifth and sixth cranial nerves are most frequently involved. The differential diagnosis between extra and intracranial involvement of these nerves is frequently impossible but New[1] calls attention to the value of noting the presence of a unilateral choked disc as favoring the diagnosis of extracranial involvement.

Neurologists have become much intrigued by the frequent presence of cranial nerve involvement in nasopharyngeal malignancy and attribute this tendency to the unusual invasive quality of that particular epidermoid cancer termed lympho-epithelioma. In this connection it is noted that Titrud and Peyton[3] report that of their 195 cases 63 per cent of the squamous cell cancer cases had neurological symptoms while 73 per cent of the lympho-epithelioma group showed such signs. In some 4 per cent of nasopharyngeal malignancies invasion of the orbit occurs usually by way of the superior orbital fissure resulting in a variety of symptoms from minor disturbances of movement to complete blindness. The following case may be cited as fairly typical of cancer of the nasopharynx.

ILLUSTRATIVE CASE REPORT

C. P., a male aged 37 years, was referred to me in July, 1943, by his family doctor. This patient consulted his family doctor in September, 1942, because of symptoms of a persistent cold in the head which was resistant to ordinary home treatment. In spite of the family doctor's best efforts the head cold symptoms continued unabated. The patient also complained of increasing stuffiness of the ears and some diminution of hearing together with pain about the left ear and face. There was occasional bloody discharge from the throat. By the following March a swelling had appeared in the left cervical area which was treated with topical applications and heat locally. The neck swelling increased so the family doctor referred the patient to a general surgeon who applied additional hot stupes locally and finally incised the swelling expecting to find a deep cervical abscess. No pus was found but a biopsy was taken and reported as lymphoblastoma. A primary lesion in the nasopharynx was then suspected and the patient was referred to me for examination in July. A large nodular tumor in the nasopharynx was observed which on biopsy was found to be lymphosarcoma. Thus the diagnosis of the primary lesion in the nasopharynx was made nearly one year after the first symptoms were noticed. The patient was given intensive roentgen therapy but expired in February, 1944.

TREATMENT OF NASOPHARYNGEAL CANCER

The treatment of malignancy of the nasopharynx at the present time is chiefly irradiation therapy. This form of therapy is indicated since malignancy of this area is especially radiosensitive and for the added good reasons that these tumors are surgically inaccessible, the growths are poorly demarcated and early intracranial or orbital extension is common. Surgical extirpation of the cervical metastases is not palliative and apparently is of little if any value. That other forms of therapy may be tried and may prove effective is illustrated by the results reported by Percy.[8] This surgeon claims good results following the use of the actual cautery to the primary growth followed by any necessary plastic repair. Cervical metastases are dealt with by block dissection.

The results of treatment are not glowing.

Hayes Martin of Memorial Hospital in New York reports 25 per cent of five-year cures in all types of cases including advanced with metastases. He states, however, that the results are twice as good if treatment is instituted before metastasis occurs. Other recorded results including our own experiences are even less encouraging.

SUMMARY

1. Swollen cervical glands, nasal blockage, ear stuffiness and diminished hearing, ear and face pain, bloody postnasal discharge or evidence of cranial nerve involvement are symptoms that singly or in combination serve as sign posts pointing to the nasopharynx as the possible site of neoplasm. Failure of doctors of medicine to heed these warning signals condemns hundreds of sufferers to misery and death.

2. Medical teaching must stress the importance of the nasopharynx as the site of disease. Its adequate and routine examination should be an integral part of every physical examination.

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Emotional Precipitants of Death

This is the basis for the well meant advice "Take it easy—remember your blood pressure." Too few physicians consider it any of their business to teach the patient how to take it easy. The advice, therefore, is usually sterile.

The case for the emotional precipitation of death seems well established. The doctor can scarcely carry on his role as preserver of life without giving serious thought to the recognition, analysis and control of noxious emotional factors. Rage and fear, fright and frustration, are not only threats to peace of mind—and thus of interest only to the psychiatrist. They are, rather, potentially destructive to life itself and thus of concern to all practitioners of medicine.—Henry A. Davidson, M. D., Flemington, N. J.; Jour. of the Medical Society of New Jersey, Vol. 46, No. 7, July, 1949.

KEEPING UP WITH MEDICINE

• THE sex relation of urticaria solaris is noteworthy and seems to be linked to hormonal factors.

* * *

• SINCE epinephrine is frequently used in anesthesia and allergy, it is well to remember that it may produce toxic symptoms. These consist of pallor, fear, chilliness, tremor, tachycardia, headache, nausea, weakness, respiratory difficulty, dizziness, anxiety, and restlessness. In allergy, we usually avoid these by keeping our dose low (below 0.25 cc.) but with anesthesia that is difficult.

* * *

• THE barbiturates often cause circulatory and respiratory depression and tend to increase the sensitivity of the laryngeal reflex.

* * *

• THE antihistamine drugs are now being used with encouraging results in human tuberculosis in the acute exudative stage.

* * *

• IT IS being reported that certain cases of migraine are responding quite favorably to the exhibition of the male hormones.

* * *

• THE theory is generally accepted now that as a result of an antigen-antibody reaction, there is a liberation of histamine, or histamine-like substances (it seems clear now, too, that histamine is not the sole mediator in the reaction), thus causing the allergic phenomena in the sensitive or shock tissue.

* * *

• KENNEDY insists that the allergic headache has not received nearly enough attention and that many cases of sudden transient cerebral and spinal illnesses can only be explained as being due to a hypersensitiveness of the allergic type.

* * *

• DURING an acute asthmatic seizure, the patient notes puffiness of the neck which cracks upon palpitation. Such is the story of the half-dozen or so cases of massive subcutaneous emphysema in the literature. Spontaneous pneumothorax is much more frequent in its occurrence.

* * *

• ONLY about 15 per cent of routine X-ray studies in asthmatic patients show both the accessory sinuses and the lump to be normal.

* * *

• THERE are still a considerable group of allergists who find that bacterial vaccines, carefully administered after proper selection, are most helpful.

* * *

• NOW, physicians are beginning to use protein hydrolysate to furnish their depleted asthmatic patient with the necessary amino acids to build new antibodies.—J. F.

Syphilis 1949

LOUIS J. ROTH, M.D.

IF THE ADVANCES made in the social and economic fields could have been proportionate to the advances made in the treatment of syphilis and gonorrhea, the final eradication of these diseases would be a foregone conclusion. The emotional state that accompanies venereal disease infections has not yet been overcome by a great many of our doctors. So, what can we expect from the public? To some of our doctors a positive blood test is like waving a red flag before a bull. A great urge overcomes him and he must get rid of that positive blood test —come "hell or high water." There is an old adage in the treatment of syphilis which says: "The first two years you treat the serology, after that treat the patient."

The Author

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IMMUNITY IN SYPHILIS

The development of immunity in syphilis greatly determines our treatment. Experiments show that up to fifteen days after the development of a chancre it is possible to inoculate another chancre. After fifteen days immunity does not allow a re-inoculation unless intensive treatment has been given. If, however, treatment is delayed until the second stage, which allows the body to develop full immunization, these immune relationships, as far as we know, are not disturbed by further treatment. To show how great a part immunity plays, Boeck,[1] the chief of the Syphilis Clinic in Oslo between the years 1891-1910, believed that little or nothing was accomplished by mercury or potassium iodide in the treatment of syphilis and that the ultimate result was equally as good if one relied almost entirely on the patient's own defense mechanism. Accordingly, all patients with primary and secondary syphilis were given no treatment, except placebos.

Within this period, there were 2,181 such patients. During the later years, 1925 to 1927, Bruusgaard set out to find these individuals. Out of the 2,181 he succeeded in reexamining 309 at intervals ranging from 3 to 40 years after their infection. In addition, he was able to determine the cause of death of 164 others. While these 473 do not constitute a random sample of the whole group, there is reason to believe that, if the whole group of 2,181 patients could have been studied, the results would have been even more favorable than Bruusgaard reports. All the living patients were submitted to thorough physical examination, with the exception of spinal test. His findings, which are never shown to an emotionally-stirred public, were as follows: With no treatment whatsoever 9.5 per cent developed neurosyphilis; 12.8 per cent developed cardiovascular syphilis, which means 23.1 per cent developed a serious, often fatal, late lesion of syphilis; 12.2 per cent developed late lesions of skin, bone or mucosa. However, if one includes the patients who died from some other disease not related to syphilis, 64.6 per cent of the total number of patients were not seriously inconvenienced by the disease, and in 25 per cent the blood test spontaneously became negative.

These statistics do not mean that we should let down an instant in our fight against syphilis. It means that if the disease is discovered early we should treat intensively. If discovered late, moderate treatment is recommended if no lesions are discovered in the nervous or cardiovascular systems. Bruusgaard's statistics, plus our modern therapeutic armamentarium, should provide the physician with a healthy ultimate prognosis, which he should pass on to his patients.

The general practitioner and internist very frequently, in their examination, find positive blood tests without any other positive findings. These patients should receive penicillin, mapharsen and bismuth, and a spinal test six months after their treatment is completed. If the spinal test is negative, but the blood test remains positive, a quantitative Kahn test should be performed, which measures in units the strength of the antigen. Instead of the old measure of strength 1 to 4-plus, we now perform this test which gives us a more accurate measure of positivity. If the units of positivity stay below 10 or 20 units and blood tests are repeated every three months, with no increase of units, we call this patient sero-resistant. If the units should start to rise, then another course of treatment would be in order. It is a well-known fact that patients with early syphilis, when treated intelligently, the blood test will be negative in 90 per cent to 95 per cent, but if treated intermittently and irregularly, the blood will re-

Read at St. Francis Hospital, Columbus, Ohio, March 21, 1949.

main positive in from 35 per cent to 70 per cent. Those who have had continuous and adequate treatment and still have positive blood should have a spinal test as it usually indicates that they have some neurologic involvement. Also, in early syphilis, there is a definite relationship between sero-resistance and occurrence of infectious relapse. In early sero-resistant syphilis the treatment is, as follows:

If spinal test is negative and if the quantitative Kahn units start rising after the completion of the first intensive course, repeat with a second intensive course. In early syphilis the body has not established the immunization that is established in late syphilis and therefore the treatment of late latent syphilis is different from that of early. The sero-resistance[2] of late syphilis does not carry with it the implication of clinical relapse. The incidence of sero-resistance of various types of syphilis, which have been treated six months to one year is, as follows:

Early syphilis (primary and secondary)		5-15%
Latent syphilis (2 years or over)		35%
Late cutaneous		50%
Late osseous		65%
Late visceral (hepatic, etc.)		50-70%
Cardiovascular		50%
Central nervous syphilis:	meningeal	10-20%
	meningovascular	40-50%
	tabes	10-25%
	paresis	70-80%
Early congenital		5-20%
Late congenital		60-80%

In these cases the utmost in treatment is not to render the blood negative but to relieve symptoms, prevent clinical progression and prolong life.

SPINAL TESTS

The timidity of doctors to perform spinals in their office is quickly transferred tenfold to the patient. The word spinal has a horrible connotation for most patients. As recently as twenty years ago it was very unusual to do a spinal in the office. The after-care of the patient following a spinal has changed radically, too. This change was brought about during the last war. Before the war, every patient was advised to go home immediately and to lie in bed, without a pillow, from twenty-four to forty-eight hours. During the war, an opposite regime developed. Many were the soldiers at Fort Benjamin Harrison who cussed their officers because they would not permit them to lie down when a headache resulted from a spinal test. This routine was reported to me so frequently that I am sure there is a lot of truth in it. The accepted method, at present is: If the patient is a nervous type, have him lie on his side, otherwise he sits up. The larger the bore of the needle the greater the chances for headache, hence I use small bore, preferably a 22-gauge needle, with a medium beveled point. And, speaking of needles, it is really surprising how the veterans appreciate a sharp needle. A small hone, two or three strokes of the needle to smooth and sharpen its edges, will win many a patient's gratitude.

Rarely, if ever, does a patient develop a headache within the first hour after a spinal test. Instructions are given him to avoid any exercise and if he does not develop a headache after twenty-four hours he may resume his usual routine. However, if a headache develops he should go to bed, lie on his abdomen for about four hours, after which he may lie on his back. The idea of lying on the abdomen being that the flow of spinal fluid will be slower this way and perhaps a small amount of fibrin may close the opening in the dura. It is very noticeable that nervous patients develop many more headaches than the phlegmatic type, and that the more insulted the nervous system has become by the spirochete the less reaction there will be to the spinal puncture; i.e., a person having paresis or some other neuro form of syphilis is less apt to have a reaction.

The spinal fluid findings are very important. Increased cell count, increased total protein and colloidal gold show activity in the nervous system. A positive spinal fluid with every other finding negative, resulting after one to two years' continuous treatment, and with no neurologic symptoms, is regarded by Dattner as a quiescent positive test and he feels that this is akin to a sero-resistant blood test.

METHODS OF TREATMENT

And now to the treatment of syphilis as of March 21, 1949, 8 p.m. The best and most recent classification of syphilis is: (1) Early syphilis, which includes primary (chancre), sero-negative, sero-positive, primary and secondary syphilis. (2) Early latent syphilis, which is the asymptomatic phase of syphilis infection under four years, with negative spinal. (3) Late latent syphilis, which is asymptomatic syphilis, with negative spinal over four years old. (4) Asymptomatic neurosyphilis, which includes a positive spinal test with no other positive findings. (5) Symptomatic neurosyphilis which includes syphilitic meningitis, paresis, tabes, meningovascular syphilis, ocular syphilis, etc. Other forms of syphilis are prenatal, cardiovascular and congenital.

Eagle has shown that mapharsen and bismuth have a synergistic effect on penicillin and believes that it adds greatly in our treatment of syphilis. Treatment of early syphilis, as given at present, is 2 cc. of procaine, penicillin in oil or depot penicillin each day for ten days, equaling 6,000,000 units, plus mapharsen intravenously twice a week until ten injections are given, and bismuth intramuscularly once a week, after the penicillin is given, making a total of thirty injections in a period of two months. This should

be followed by monthly quantitative Kahn tests for six months. Approximately 90 per cent, if treated this way, will become negative at the end of six months. At this time a spinal test should be performed. It has been shown that the ultimate effect of penicillin on the spinal fluid is six months after the end of treatment.

The treatment for late latent syphilis is the same as for early syphilis, but do not expect the blood test to become negative as frequently as in early syphilis. If the treatment just described is given and the spinal test is negative, but the blood test remains positive, and the titer in the quantitative Kahn is low, further treatment is not necessary. Blood test should be taken once a year.

In cardiovascular syphilis one must be careful of the Herxheimer test. In order to prevent a severe reaction it is advised that the patient have 10 to 20 bismuth injections—one each week, followed by penicillin, starting with 50,000 units a day and gradually building up this amount until 600,000 units a day are given, making a total of 5 to 8 million units given. Mapharsen intravenously may be dangerous (aneurysm, aortitis).

Congenital lues can be treated, as follows: Infants under two years—100,000 units to 400,000 units aqueous penicillin per kilo of body weight, over a period of eight to fifteen days. Late congenital syphilis should be treated similarly as late latent syphilis.

TREATMENT OF POSITIVE BLOOD TEST IN PREGNANCY

Penicillin is far superior to mapharsen and bismuth in treatment of prenatal syphilis. There are practically no reactions and, if treated with 5,000,000 units of penicillin, before the fifth month, the fetus will be protected in about 95 to 98 per cent. Recently, from Johns Hopkins,[3] a study of 363 women, with varying types of syphilitic infection, who previously had received chemotherapy, were observed through 570 subsequent pregnancies in which further antisyphilitic treatment was purposely omitted. Of these (1) twenty-two women with early syphilis, all of whom were originally treated with penicillin, were observed through 26 subsequent pregnancies, with no further treatment. (2) Of the 596 infants born of these pregnancies, the mothers being untreated, 92 per cent were born alive. (3) Twenty-eight of the 48 stillborn or miscarried were examined at necropsy, with no evidence of syphilis. (4) Of the 549 infants born alive 88 per cent have been carefully followed for more than two months; 70 per cent for more than one year. All the children were normal.

These data indicate that it is not necessary to administer antisyphilitic treatment to a syphilitic woman during every pregnancy, providing that the mother has previously received 10 to 20 injections of mapharsen and 10 to 20 bismuth, or 2½ to 5 million units of penicillin. This treatment may have been administered during a previous pregnancy or during a non-pregnant interval. No further treatment is needed if the mother shows no clinical signs of active syphilis infection, even though the blood test is positive but shows a low titer, i.e., 10 units or lower.

Evidence is accumulating rapidly that in penicillin we have a drug superior to any other for treating neurosyphilis. In asymptomatic neurosyphilis there is a prompt reduction of the cell count, and the protein content. The complement fixation and colloidal test improve more slowly. The maximum effect is realized six months after treatment has ceased. The treatment is the same as in early syphilis.

In paresis or tabo-paresis we now give 8 to 10 million units of penicillin plus mapharsen, plus bismuth.

The addition of fever treatment is advised by some. Other authorities seem to feel that the results with penicillin alone are just as effective. Over 50 per cent of the paretics show definite improvement; 20-40 per cent no improvement, and 6-10 per cent die within two years after treatment.

In tabes, the treatment is the same as paresis. Decrease in frequency and severity of the lancinating pains occur in 50 per cent of the patients. Improvement in paresthesias, gastric crisis and ataxias also occur.

Stokes and others say: "Serologic reactions in the blood by the third year still show little relation to spinal fluid and clinical symptomatic improvement. The same proportion of bloods fail to improve as spinal fluids do improve. A comparison of penicillin with other antisyphilitic therapy, including malaria, in neurosyphilis, indicates that in paresis penicillin "catches up" on malaria by the third year, equaling it in symptomatic improvement, and producing superior effect on the spinal fluid. In taboparesis and meningovascular neurosyphilis the results with penicillin are serologically superior and equal clinically to those with malaria. In tabes dorsalis the clinical improvement is one-third better than with malaria in the second and third years, and spinal fluid normality is obtained twice as often with penicillin as with malaria in the same period. In asymptomatic neurosyphilis the results obtained with penicillin are the best in any diagnostic category (60 to 61 per cent normal and near-normal fluids) and are held into the second and third years.

The old adage that the amount of cure depends on the amount of parenchymatous tissue that has not been replaced by scar tissue still holds, thus the earlier any syphilitic lesion is attacked the more favorable will be the results.

Syphilitic iritis is treated with the same regime as early syphilis. Interstitial keratitis should have penicillin 10 million units, mepharsen, bismuth and fever therapy. Optic atrophy, which results in 10 to 15 per cent of blindness, is treated the same as interstitial keratitis, with emphasis on malaria and penicillin.

Penicillin, in its present purified form, is relatively non-toxic for man except when administered intrathecally. No deaths clearly attributable to penicillin have been reported. In the early days of penicillin a number of cases of acute exfoliative dermatitis occurred, confining the patient to bed from seven to ten days. However, this is rare now. We occasionally see a macular or papular rash, fever and, most frequently, an urticaria. This urticaria may develop ten to twenty days after the last injection of penicillin. Patients should be questioned whether they itch before each dose of penicillin. The urticaria usually can be controlled by 50 to 100 mg. doses of an antihistaminic every four hours. Penicillin has produced evidence of therapeutic shock or Herxheimer reaction in about 50 per cent of early syphilis. About 25 per cent of patients with late syphilis have experienced a mild reaction. In neurosyphilis the therapeutic shock is rarely serious although exacerbations of psychosis, convulsions, transverse myelitis, lightning pains, etc., have been reported.

FALSE POSITIVES

Our tests for syphilis have become more numerous and more sensitive. In taking histories at our clinic at least 70 per cent of the women and 40 per cent of the men showing positive blood test never remember having had a sore or an eruption. I do not believe that they have convenient memories—but that it is actually so.

We know that a general infection reaction mechanism, shared by many diseases, is more developed in some persons than in others, that febrile states such as infections, virus diseases, especially naso-respiratory and gastro-intestinal, foreign protein inoculations and certain diseases such as leprosy, malaria, infectious mononucleosis and relapsing fever are prone to give biologic false positives. Stokes[4] says that false positives may be as high as 40 per cent in a series of routine positives, but the proportion of false positives in all tests (positive or negative) does not exceed one in 700 tests. It is important to evaluate each case. There should not be too great haste to perform a cure. Numerous quantitative tests from different laboratories, at different times, are a great asset. A spinal test also gives valuable information. If there is a strong doubt, a patient may be given 5 million units of penicillin as a prophylactic, without indicting him or her with a diagnosis of syphilis.

There are many things we do not know about syphilis. The true nature of the life history of the spirochete is still obscure. It is indistinguishable from the spirochete microdentium, a harmless inhabitant of the mouth.

Only a few animals are susceptible to syphilis —mice and rabbits.

FEW THINGS UNKNOWN ABOUT SYPHILIS

Some of the questions we would like to have answered are: Why do the thyroid, pancreas, kidneys and ovaries remain practically immune? Why is squamous epithelium attacked and columnar epithelium untouched? Why is the pharynx attacked and the stomach rarely involved, and the gastro-intestinal tract never involved?

No disease so profundly affects the fetus, yet the maternal disease is milder than that of the non-pregnant woman. The gray matter degenerates in paresis with heavy infestation of organisms whereas the white matter is affected in tabes with few organism, which are very difficult to find. Conjugal syphilis is often tabetic in one partner and paretic in another. Why do we have no interstitial keratitis in acquired syphilis? Why is juvenile paresis much more frequent than juvenile tabes, which is rare?

CONCLUSION

We now have marvelous drugs to combat venereal disease. While the rate of syphilis is going down slowly, gonorrhea is on the increase. The soldiers have come back from the war where they were compelled to see movies on venereal disease; they were compelled to hear lectures on venereal disease; they were compelled to take prophylactics; they were immersed and almost drowned in venereal disease knowledge. Yet, they come to our clinic with chancres and gonorrhea. I asked them: "Didn't they tell you, show you and make you know about venereal disease?" "Yes, sir," they reply. "Then, how come," says I, and they reply: "I forgot—she was different—and I took a chance, etc., etc., etc." What is the answer? My belief is that the only answer is to get rid of slums, raise the standard of living until the social and economic lower third will acquire education and a sense of morality that comes with better living.

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Pregnancy Complicated By Regional Ileitis

WILLIAM C. WEIR, M.D., ARGYLE J. BEAMS, M.D., and FRANK S. GIBSON, M.D.

THIS CASE is reported because of the unusual sequence of signs and symptoms leading up to the diagnosis and because of the rarity of the condition. No reference in the literature could be found to a similar case. The underlying pathological condition, regional ileitis, was not suspected and only when the diagnosis was finally made did the symptomatology become clear.

CASE REPORT

A. C., a 28-year-old white native of Georgia, had an uncomplicated pregnancy and normal low forceps delivery of a six-pound six and a half ounce baby boy on February 7, 1947. Following this she had a retroversion of the fundus which was easily held forward with a Smith-Hodge pessary. She was next seen on March 28, 1948, and her last menstrual period had been December 23, 1947. Examination showed the uterus to be the size of a three months pregnancy. She had had some nausea but no vomiting and except for tiring easily felt quite well. Her general physical examination was normal, weight 110 lbs., blood pressure 110/68, urine normal. The past history revealed considerable seasonal hay fever with urticaria. Her appetite and digestion had been normal. Later she recalled episodes of abdominal discomfort and diarrhea for a period of one or two years.

Following a trip to Georgia for three weeks, she was seen on July 12, 1948. She complained of abdominal cramps, diarrhea, and lassitude. Examination showed the fundus to be three centimeters above the umbilicus. The fetal heart was normal. There was generalized abdominal tenderness but no masses could be felt. She had some psoas tenderness, finding it more comfortable keeping the right leg partially flexed.

She was admited to the hospital that day. A catheterized urine was normal. The red blood count was 3,540,000; hemoglobin 9.85 gms; and white blood count 11,350. The corrected sedimentation rate was 0.8 mm. per minute; weight 114 lbs.; blood pressure 110/62. Because she had always been somewhat underweight, she had frequently been checked for tuberculosis. A chest plate was entirely negative at this time. A stool examination was negative for blood, parasites, and ova. Her symptoms rapidly subsided and she was discharged four days later. She was seen at intervals and complained of some abdominal cramps and diarrhea but not severe. The fundus enlarged steadily and the fetus was active.

On September 11, 1948, her pregnancy being at that time 38 weeks, she was again admitted to the hospital. She complained of lower abdominal cramps and backache for three weeks. For five days she had had marked and increasing pain in the right lower quadrant, flank, and costo-vertebral angle, with chills and fever. On admission the TPR were normal; the blood pressure 108/68. A catheterized urine showed only an occasional red blood cell and white blood cell. The hemoglobin was 8.85 gms. and the white blood count 19,950. Two days later the blood chemistry was as follows: BUN 7.8, NPN 24.0, Uric Acid 3.5, Ser. Prot. 6.55, Alb. 3.62, Glob. 2.93, A/G 1.23 and Cell Vol. 37.5 per cent. The corrected sedimentation rate was 1.95 mm. per minute. Intravenous pyelograms showed a marked hydronephrosis on the right and slight on the left. (Figure 1.)

Except for the very rapid sedimentation rate and the elevated white count, there was no evidence of urinary infection. Because of the sudden onset and increase of the right ureteral pain, it felt advisable to deliver the baby as soon as possible. On September 14, 1948, a low transverse cervical section was done and a six-pound six ounce living male baby was delivered. Because of the patient's condition and the size of the fundus, a complete exploration of the abdominal cavity was not done. After the operation she had some residual right ureteral pain which gradually subsided during the first week. Repeat intravenous pyelograms eight days postoperatively showed a marked reduction of the hydronephrosis on the right. (Figure 2.)

In preparing the patient for the second pyelograms, she was given castor oil which had not been used with the first. As a result she developed severe abdominal cramps and diarrhea which did not subside as expected. These continued for days and could only be controlled with morphine or demerol. A gastro-intestinal X-ray examination on September 30, showed a marked pylorospasm but there was no filling of the lower intestine at the time. Except for morphine all attempts to control the intestinal symptoms including aluminum hydroxide and hot stupes were to no avail. Her appetite was very poor and she was steadily losing weight. An X-ray of the small intestine on October 15 was reported as: "Numerous fluid levels in the right abdomen, dilated ileal loops filled with intestinal contents, fluid, and barium and was unsatisfactory for good detail and mucosal study of the small intestine. These changes are probably on an inflammatory basis. The etiology is undetermined at this examination."

With these X-ray findings and the signs and

Submitted April 15, 1949.

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Figure 1

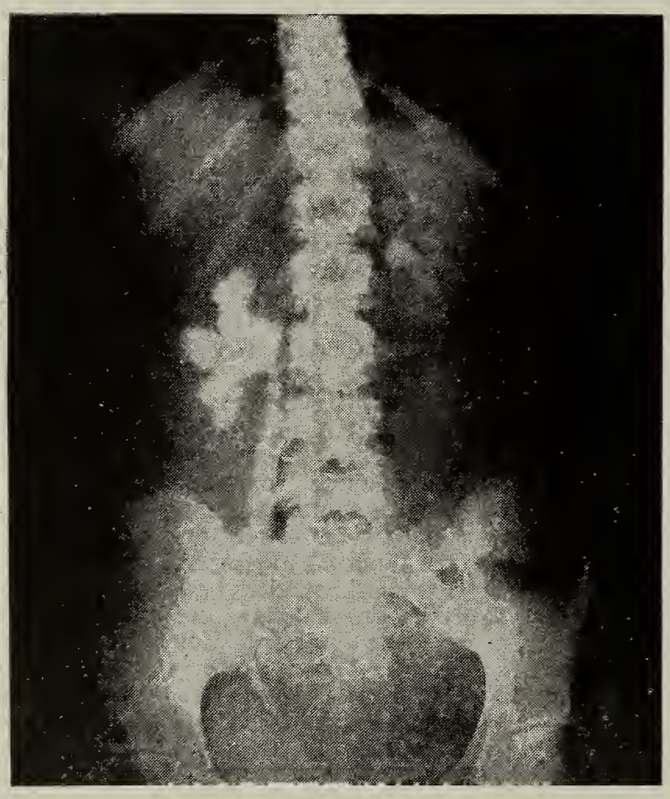


Figure 2

symptoms which had developed, a diagnosis of regional ileitis was made. A laparotomy on October 20, showed this to be present. A loop of involved ileum was adherent to the right latero-posterior side of the pelvis over the ureter and a subacute obstruction was present. Because of the poor condition of the patient, a resection was not attempted. Instead a loop of normal ilium was anastomosed to the transverse colon, as a first stage of two-stage operation.

DISCUSSION

The clinical picture was now quite clear. The regional ileitis probably had been present for some time, but was not suspected in spite of the presence of diarrhea and cramps earlier in the pregnancy. The cause of the right hydronephrosis was also undetermined at the time it was discovered. It was not until the severe intestinal symptoms developed following the castor oil which did not respond to the usual medical treatment that the underlying pathological condition was suspected. X-ray examination showed obstruction in the lower ileum and laparotomy finally confirmed the diagnosis of regional ileitis.

The sequence of events was now easily reconstructed. A regional ileitis was present for an unknown length of time. A loop of involved terminal ilium hung over the brim of the pelvis on the right side or was pushed down as the fetal head descended. The enlarging head pushed this loop against the right latero-posterior aspect of the pelvis over the ureter. The inflammatory process was not acute enough to cause obstruction but was sufficient to cause cramps, diarrhea, and psoas tenderness on the right at the time of the first admission in July. As the pregnancy progressed, the fetal head pushed the loop of ileum against the pelvic wall and the ureter became involved in the inflammatory mass. As a result the ureter was gradually obstructed and the hydronephrosis developed. Following the section, the pressure on the ureter was relieved and the hydronephrosis decreased. The castor oil given in preparation for the second pyelograms aggravated the regional ileitis. The symptoms increased and obstruction became evident. The diagnosis was then easily made.

A resection of the involved terminal ileum, the ascending colon, and hepatic flexure was done on January 5, 1949. Her condition has shown steady improvement up to the present time.

Ruptured Intervertebral Discs

On examination the patient usually presents evidence of neurological disturbance of the nerve roots involved. Thus, one will get a diminished ankle jerk most frequently when the sciatic nerve is involved; also the knee jerk may be diminished as compared with the opposite one. Corresponding disturbances in the upper extremities may be found when dealing with a cervical herniation. There is sensory disturbance, as you may expect, in the distribution of the nerve involved. It is easily found by testing with a pin or cotton. Rarely the vibratory and position sense are disturbed. The anesthesia usually bears some anatomical distribution which is highly suggestive and localizing.—Senseman, Hamlin & Umstead; Rhode Island Med. Jour., Vol. XXXII, No. 7, July, 1949.

Ten Per Cent Crotonyl-N-Ethyl-O-Toluidine Ointment (Eurax), A New Scabieticidal Agent*

ARTHUR J. TRONSTEIN, M. D.

DURING World War II the incidence of scabies rose tremendously. In Naples over 50 per cent of the population has been reported as having been infested. Even in Switzerland, which was spared by the war, Schuppi[1] reported a five-fold increase in its incidence during the years 1939-1940. Cannon and McRae[2] state that in our army, scabies was the fifth most common dermatological condition. Private practitioners see the disease frequently enough to recognize that it creates serious economic loss, and that it has serious psychosomatic implications. These psychosomatic factors may make the patient truly ill out of proportion to the clinical picture presenting in any individual case. Goldman[3] has shown that scabies is not the simple disease it appears to be, and that serious complications may follow the disease or its treatment.

Until recently, we have depended for therapy upon a rather limited group of medicaments. Results have been somewhat less than might be considered ideal. More recently, because of military need, newer preparations such as DDT formulae and gammexane have been used. Eddy[4] has reported recently some investigation on some new synthetic compounds.

Such long-used materials as sulfur, balsam of Peru, and benzyl benzoate may have, in some instances, disagreeable odors, may be difficult to apply, may produce contact dermatitis, and do potentially possess toxicity. Postel[5] has reported such possible toxicity for benzyl benzoate. However, benzyl benzoate mixtures have been used in The Department of Dermatology and Syphilology since they were introduced here by Goldman in 1936, and no systemic reactions have been noted. The toxic potentialities of sulphur or sulphide containing materials have been reported upon by Funk,[6] Burmeister,[7] Niemeyer[8] and Barrett.[9] The general toxic reactions, in particular upon the kidneys, are well known for phenol, naphthol, and balsam of Peru.

In spite of these circumstances, until recently little has been done to study the actual affects of various miticidal agents upon isolated organisms under laboratory control. Modern research technic demands detailed laboratory study and controlled field work before widespread clinical use may be permitted. Such policy is followed for example, by The Bureau of Entomology and Plant Quarantine, Agricultural Research Division, of The Department of Agriculture. Domenjoz[10] was probably first in Europe to employ preliminary laboratory methods prior to clinical evaluation. Working with Psoroptes cuniculi isolated from rabbits, Domenjoz developed certain fundamental concepts of evaluation of the miticidal value of numerous products. During these studies, some 1,100 newly synthesized chemicals were studied under closely controlled laboratory methods. He concluded that crotonyl-N-ethyl-O-toluidine best combined safety, pharmaceutical adaptability, rapid peak action, effective range of activity, and bacteriostatic action. Burckhardt and Rymarowicz[11] used the material in a 10 per cent ointment form for 326 clinical patients and in 152 patients in an isolated mountain village with excellent results. Other clinical studies have confirmed Domenjoz's findings. No serious side reactions appear in the literature. In this country, Couperus, Peck and Kierland,[12] among others have been studying this compound in respect to scabies and similar infestations.

Crotonyl-N-ethyl-O-toluidine is a colorless, odorless, stable liquid. It is capable of withstanding deterioration. Of importance in respect to its biological effect, is its relative insolubility in water, although readily soluble in ether, acetone, alcohol, fats and oils. Clinically it is used in a 10 per cent suitable ointment form. It has a high bacteriostatic action, and this is of great value in view of the frequency of secondary infection in scabies.

In view of these findings, we attempted to evaluate the compound clinically. Not only were we interested in its miticidal action, but we were also interested in it as a symptomatic, antipruritic agent. Reference to this action will be

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* Ten per cent Crotonyl-N-ethyl-O-toluidine ointment (Eurax) for this study supplied by J. R. Geigy Co., New York.

From the Department of Dermatology and Syphilology, College of Medicine, University of Cincinnati, Leon Goldman, M. D., Director. Submitted April 12, 1949.

made later, but a more critical study will be reported in the future. We were also greatly interested in any potential or actual sensitization properties it may possess, and also its adaptability for use in other dermatological conditions.

CLINICAL STUDIES

Patients were obtained from The Outpatient Department of the Department of Dermatology and Syphilology of Cincinnati General Hospital and its allied services. Some patients were obtained from the private practices of the staff.

No selection of patients was made. The patients represented all age groups, both sexes, and both races. If a definite diagnosis could not be made, every effort to find the Acari was employed. If none could be found, the case was excluded from this series. Since most of the patients were from the lower economic strata, various factors hindered peak efficiency. Lack of laundry or bathing facilities; inability to read written orders or to remember oral orders (we always gave a patient a printed instruction sheet); and similar factors were involved. If we found that a patient had used the material more often than the prescribed number of times, we excluded the case from our results for this study. As often as possible, cases were followed a minimum of three weeks following therapy. Judgment as to reinfestation or failure is often difficult. However, we felt that if a patient remained free of objective or symptomatic signs for at least thirty days, any new findings represented reinfestation. Due to certain limitations upon our supply, we could not treat large habitation units simultaneously. We did attempt this in a few cases, only to have them fail to return, etc. This may have led to possible reinfestation which could have been prevented under usual conditions.

When involvement was mostly limited to the usual sites of predeliction and generalized dermatitis was not marked, we graded these as "average." If the scabietic involvement was very extensive, and secondary allergic responses were or were not present, we graded these as "extensive." When impetigo-like lesions, or pustules or ecthyma, etc., were also present, we indicated these as "pyoderma present."

Eighty-nine patients were treated by our "two application method." In this method the patient is advised to take a thorough bath at bedtime. After the bath, half the contents of the tube (70 gm. per tube) is rubbed in well over the entire body from the angle of the jaws to the soles of the feet. The remaining half tube is so applied at the following bedtime, and the next morning, another bath is taken. Clean clothing is then to be worn, and proper laundering of contaminated clothing, linens, etc., is advised. There is some doubt as to the necessity of this "clothing and bathing" factor. In many cases such bathing or laundry facilities were not available, but we considered these as having been properly treated even though we knew such facilities had not been utilized. Results of treatment by this method are shown in Table 1. The single failure noted might have

TABLE 1
TREATMENT BY TWO APPLICATIONS

No. Pts. Treated	Extensive Involvement	Average Involvement	Cured	Failed
89	22	67	88	1

been a case of reinfestation since it appeared in a habitation unit group in which we had considerable difficulty in controlling an outbreak. However, under our criteria, we were forced to consider it as a failure.

Twenty patients were treated by our "single application method." In this method we ordered a bedtime bath followed by a single application over the entire body as in the previous method. No bath is taken until the following bedtime, twenty-four hours later. The usual advice concerning clothing, etc., is given. Again, we did not exclude those cases in which bathing, etc., was not carried out. Results of treatment by this method are shown in Table 2. In both in-

TABLE 2
TREATMENT BY SINGLE APPLICATION

No. Pts. Treated	Extensive Involvement	Average Involvement	Cured	Failed
20	6	14	18	2

stances cited as failures there is some doubt that the material had been applied properly. Both patients went on to full cure when the method was repeated. However, these second applications were not included in this report of either series of treatments.

Forty-eight of the cases showed pyoderma present as a concomitant finding. We have not attempted to grade these as to severity. Of the 48 cases, 29 showed sufficient improvement so that they went on to cure without any further therapy. The other 19 cases showed sufficient improvement to indicate the value of the material, but more treatment was deemed needed for cure. It is worth noting, however, that it is rare in practice to limit therapy for pyodermata to one or two local applications of a therapeutic agent. Certainly the bacteriostatic value of this product is well demonstrated.

We noted no evidences of local irritation, sensitization, or systemic toxicity. In a fairly good number of cases we purposely allowed the patient to use the material for post-scabietic pruritus (which we are inclined to believe may be of central origin) for periods as long as a month without noting any ill effects. In a few in-

stances under such regime, very mild erythema was seen. One patient accidentally applied a goodly amount both in and on the eyes with only very mild erythema production following this procedure. Goldman, Couperus, and this author have all used the product for cases of Phthirus pubis infestation of the cilia with good results. Goldman has also used it for cat flea infestation, and in a case of larva migrans. Another patient used the material for several weeks for "diaper rash" as a "baby cream." The dermatitis cleared rapidly, and no irritation was produced. It has also been applied for several days at a time over fairly extensive areas of ulceration and eczematization about the lower extremities with no evidences of irritation, and with definite value as a bacteriostatic and antipruritic agent.

In many instances itching was relieved in from one to three hours after the first application. For such pruritus as remained after the routine use of this material, we used a simple zinc-talc lotion. (Formula: zinc oxide powder 20.00, powdered talcum 20.00, glycerine 10.00, distilled water q. s. ad. 100.00.) In certain cases after we had reached a conclusion as to results of the therapy for scabies, we allowed the patient to continue the use of the medicament for its antipruritic effect. It is noteworthy that the state of irritation of the skin at the onset of therapy is no definite criteria as to ability to control itching in any given case. Some of the most extensively involved cases gave excellent responses, while others with mild involvement were resistant to therapy for itching. Acaraphobia, once established, may persist for long periods of time after good dermatological treatment. Lichen urticatus may also prove very resistant. Goldman has suggested that lichen urticatus may be part of the picture of scabies in children. A more detailed report concerning the use of this compound as a symptomatic anti-pruritic agent will be made later.

SUMMARY

1. One hundred and nine scabietic patients were treated with a 10 per cent ointment of crotonyl-N-ethyl-O-toludine (Eurax). Eighty-nine were treated by a "2 application method" with only a single failure; 20 patients were treated by a "single application method" with two failures.

2. Forty-eight cases presented pyodermata with the scabies, and in all cases definite improvement was noted following treatment for scabies.

3. No ill side-effects such as local irritation, sensitization, or systemic toxicity were noted. In rare instances after prolonged use, slight transient erythema was produced.

4. The material has definite antipruritic value, is pleasant to employ, and acts promptly.

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Certain Epidemiologic Aspects of Poliomyelitis

I cannot escape the belief that were fecal spread of significance we should find higher infectiousness in the late convalescent stages when the virus is found only in the feces than in the early stages when it occurs also in the throat. The evidence strongly suggests that g r e a t e r epidemiologic significance must be attached to the relatively small quantities of virus occurring over a brief period of time in the throat than to the more protracted occurrence of larger quantities in the feces.

There are many other reasons, I believe, for rejecting the hypothesis of insect spread or of spread through fecal contamination of water supply. These include the failure of poliomyelitis outbreaks to cease with sudden changes of weather, the frequent development of outbreaks in the face of weather adverse to insect survival, and the striking lack of correlation with water distribution systems or the pattern of distribution of milk or other foods. No one can deny the proven bacteriologic possibility of spread through water as shown by Paul or through flies as demonstrated by Sabin and Ward, but there is an obvious distinction between a bacteriologic possibility and an epidemiologic probability. While I would not question that cases can be and may actually have been spread through such channels, I find it difficult to accept either as a channel which will explain the mass phenomena of this infection. The only hypothesis consistent with bacteriologic evidence that is adequate to explain the currently known facts of occurrence is, I believe, that of spread through respiratory association.—Gaylord W. Anderson, M. D., Minneapolis, Minn.; Texas State Jour. of Medicine, Vol. 45, No. 7, July, 1949.

Common Eye Injuries

ROBERT S. ROSNER, M. D.

EYE injuries merit consideration not only because of the suffering and visual loss produced but also because they are a frequent factor in compensation awards and lawsuits. The physician should make careful observations and record his findings; the vision should be tested in the uninjured as well as the injured eye.

There is no doubt that the incidence of eye injuries in industry have diminished because of safety regulations. Parents must warn their children against carelessness in playing with sharp instruments, bows and arrows, sticks, bb guns, explosives and stones. I recently saw a 12-year-old boy with an intra-ocular glass fragment gotten by hitting a bottle with a baseball bat.

CORNEAL FOREIGN BODIES

Those that cannot be removed with a moistened cotton applicator should be gently removed under good illumination with a sharp spud using .5 per cent pontocaine for local anesthesia. The eye should not be patched if there is no ulcer.

CORNEAL ABRASIONS

This painful injury occurs from scratches from finger nails, the sharp edge of paper, wire springs, twigs and similar objects. It is necessary to use atropine and an eye patch; occasionally the ulcer requires chemical cauterization to stimulate healing. The ulcer may recur after a few months if the newly formed epithelium breaks down.

Burns around the eye may result from hot liquids, acids, alkali, irritant gases and explosions. The danger of such injuries is to the cornea which opacifies, and when this occurs the prognosis is grave. It is safe to instill heavy oil such as olive or mineral oil for first aid. Lime burns should be promptly and thoroughly washed with 2 per cent boric acid solution or better still, 4 per cent ammonium chloride after using a local anesthetic of one-half per cent pontocaine. During the healing stages efforts should be made to prevent the conjunctiva from adhering to the globe, by glass probing into the fornices. The eye should be bandaged. Acid burns require immediate irrigation with any non-irritating fluid that can be obtained at once; clean tap water may be used. SO_2 and other refrigerants occasionally spray into the eye causing a "freezing" injury.

CONTUSION INJURIES

A blow that strikes the eye transmits its force in all directions so that many varieties and combinations of injury may result. Rupture of the globe occurs chiefly behind the cornea where the sclera is thinnest; the lens together with some vitreous may escape through the scleral wound. The eye becomes mushy and must be enucleated. In less severe blows the lens may be dislocated either backward or forward. A tremulous iris gives the clue to this injury; secondary glaucoma often follows. When the lens capsule has been injured, traumatic cataract invariably results. If a massive hemorrhage is present in the anterior chamber and does not absorb, a paracentesis with irrigation becomes necessary. Vitreous hemorrhages absorb slowly. Traumatic rupture of the retina and choroid are of serious nature and may follow relatively minor blows.

PENETRATING INJURIES

This important group includes punctures, lacerations, ruptures, and retained intra-ocular foreign bodies. Wounds that involve the ciliary body are especially dangerous; the ciliary body may prolapse and iridocyclitis may follow. This may lead to sympathetic ophthalmia, the most dreaded eye disease. Therefore, if the injured eye is inflamed, painful and the vision bad, enucleation should be advised. In wounds around the cornea with iris prolapse, the iris should be slightly drawn out and the prolapsed portion cut off. The eye should be atropinized. Sometimes a small foreign body enters the globe without the patient's knowledge, X-rays should always be taken whenever this is suspected. If a piece of iron remains in the eyeball for sometime, a condition known as siderosis results. Chemical changes then take place that lead to degeneration of the globe. X-rays are of great value in getting the exact location of a foreign body in preparation for its removal. A magnetic foreign body is usually easy to remove. Occasionally one has success in removing a non-magnetic foreign body but it is no easy task.

CONCLUSION

Eye injuries occur frequently and their importance is obvious when it is realized that the eye is a delicate organ whose only function is vision. Since relatively insignificant injuries can cause great harm, prophylaxis and intelligent first aid may often preserve sight.

Submitted January 12, 1949.

The Author

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Rehabilitation in Small Communities

SHELBY GAMBLE, M. D.

REHABILITATION, medically speaking, is a word that has great variance of meaning. Depending upon the degree of handicap present, it may range from a maximum of complete restoration to a minimum of enabling the individual to be partially independent so far as his daily needs are concerned. Even the attainment of self-sufficiency in toilet habits may help surprisingly in the economic problems of the patient's family, thus freeing another member of that family for gainful employment and eliminating or reducing the need for financial assistance with its resultant drain on family or community. I believe that Dr. Donald A. Covalt of New York City has summed up the over-all picture in rehabilitation competently when he states, "The purpose is to teach the disabled patient to live within the limits of his disability, but to the hilt of his capability."[1]

It is, of course, easier to discuss the ideals of such a program than to adhere to its practical application. Rehabilitation should begin when the patient is first disabled, as in certain injuries, or when it appears that he may become disabled as is frequently foreseen in some forms of arthritis. This may mean the prevention, as far as possible, of complications such as contractures, atrophy of muscles, ankylosis of joints, loss of general muscle strength or coordination of movement of the injured as well as of the uninjured part from disuse. In patients suffering from severe rheumatoid arthritis or a combination of neurological problems, it may mean complete vocational rehabilitation. Time could be saved and better results obtained if an early general survey were made on all patients, defining their immediate needs and future possibilities, and instituting an appropriate program.

PHYSICAL THERAPY

In small communities, this over-all plan should start at the local hospital, making use of a department of physical therapy. Although the department may be small and initially require only the part-time services of a physical therapist, a great deal could be done in preventing deformity, preserving and restoring muscle and joint motion, aiding in ambulation, and maintaining the best possible general condition of the patient.

Last but not least are the over-all aspects of psychotherapy which all patients need when "beset" by the incidental worries and apprehensions of possible permanent disability.

An address given before the Ohio Council for the Handicapped at the Ohio Welfare Conference, November 16, 1948.

The Author

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COORDINATION OF MEDICAL SPECIALISTS

Needless to say, this program must have the cooperation of the staff and hospital administrations as well as the direct supervision of an interested and competent physician. Each patient must be evaluated and consultation obtained with those medical specialists and technical advisors who are considered necessary to the patient's welfare. Unless there is a strong possibility of the patient being helped by one means or another, such a department becomes a "dumping ground" for all types of cases; the staff and personnel lose interest because of the lack of improvement and there is no room for additional and more treatable cases.

It is foolish to think that all individuals can be helped. Some are too disabled, and others weak both physically and mentally.

OCCUPATIONAL THERAPY

The next step in further development on a local hospital plan would be a department of occupational therapy. Occupational therapy may be used by itself or as a supplement to physical therapy, as it is a treatment based on activities. A definite program may be provided in which some mental or physical activity is scientifically supervised by trained technicians for a specific purpose. Occupational therapy may be indicated for improving or maintaining morale; it may be entirely diversional, educational or recreational, or functional in the sense of restoring articular and muscular coordination, building up strength and physical endurance; it may be prevocational in the sense of being planned to reinstate the patient in his former job or to prepare him for new vocational training.[2]

STATE RESPONSIBILITY

It is my opinion that little more can be done in a small community hospital with a limited bed capacity. Slightly larger institutions could set aside a few beds for those patients needing extensive physical or occupational therapy for a temporary period. The average small department of physical medicine might thus provide the initial step in rehabilitation, emphasizing

as its objective the shortest convalescent period with the greatest possible functional return.

Further attempts at rehabilitation should be the problem of the community and in turn the State. It is a waste of money and effort for every civilian hospital to install expensive equipment, segregate bed space and employ high-priced personnel. Besides, it is impossible at this time to obtain personnel to competently supervise an over-all rehabilitation program. Bed and board must be available to those unable to go back and forth; some nursing supervision plus considerable orderly and nurse aid help is necessary. However, unlike the routine in regular hospital wards, many patients could help themselves and others. This would in itself be a motivation for functional activity, which is our basic desire.

In the majority of cases, handicapped patients wish to be treated in friendly and familiar surroundings. It is also important that community resources be taken into consideration both for training and placement of the individual along vocational lines.

CASE FINDINGS

Regular or traveling clinics specializing in case findings, as advocated by Dr. Howard A. Rusk,[3] would be sufficient initially in recommending and referring patients to the available rehabilitation services in the area. It is possible that the more severely handicapped might be referred to a few highly specialized centers in the state. This is especially true in considering vocational adjustment which is based on a program of selected work activities and vocational training in combination with, or supplemented by, work tests, psychologic and aptitude tests, vocational guidance and counseling.

Finally, there will always be the person who cannot be trained for a job in industry and who presents the necessity for a sheltered work shop or home industry program, depending upon the degree of handicap. In this way the patient may be at least partially self-supporting.

COORDINATED PROGRAM ESSENTIAL

The foregoing conclusions concerning rehabilitation are based on one essential necessity —cooperation among all concerned: patient, doctors, hospital personnel, local industry, insurance companies and the various agencies with their respective staffs.

We are aware that many agencies undertake the assistance of crippled children; unfortunately there are few such groups concerned with handicapped adults. An encouraging fact is that more and more organizations are becoming active in over-all rehabilitation. This is necessary because of the limitations imposed by Federal and State Vocational Rehabilitation Acts.

I believe that one of the main difficulties encountered in an over-all rehabilitation plan is the red tape procedure and the extended time element involved. The average doctor and hospital administrative official sooner or later becomes disgruntled with the present system, thereby losing interest and offering only passive cooperation. I think it therefore essential that a "contact man" be available, with the knowledge of how, when and where to obtain what is needed and coordinate it in the best interest of all concerned.

In centers of rehabilitation this could be efficiently brought about by grouping representative offices with regular and planned general staff meetings. In this way an immediate solution to many problems could be obtained by simply "talking things over."

No one can outline a definite program that will fit all communities; this is an individual problem for each concerned. We can only hope by exchanging ideas and stimulating thought in the medical profession and allied fields, that eventually a practical, workable and active plan of rehabilitation may be developed to the satisfaction of all organizations and agencies, industries and communities involved.

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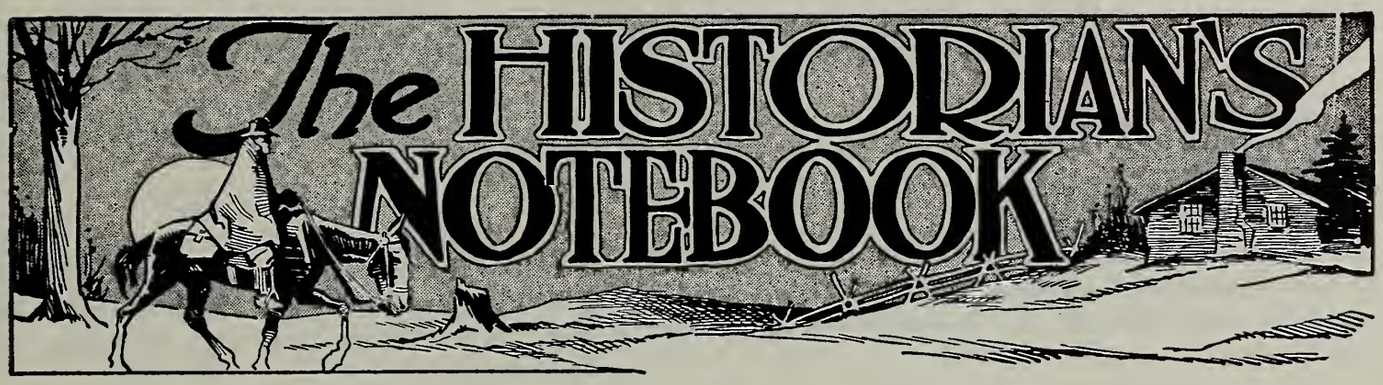
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Treatment of Chronic Alcoholism

The following indications for pentothal therapy have been evolved from our experience with this treatment during the past eight years:

1. Any patient, who drinks primarily to relieve nervous tension or emotional strain and who is nervous even when he is not drinking, is given pentothal therapy as an adjunct to his conditioned reflex treatment.
2. Any patient under thirty years of age is routinely given pentothal as well as conditioning. We have found conditioning alone to be of little value in the younger alcoholic, presumably because alcoholism in a younger person means a more severe personality deviation than in an older patient.
3. Combined pentothal and conditioning is given to any patient who has a psychopathic personality or gives a history of a psychosis or neurosis.
4. The combined treatment is given any patient with a criminal record.
5. Pentothal is given either alone or in combination with reconditioning in patients who have relapsed after one or two previous conditioning treatments.
6. Pentothal is given alone in a few patients who are unable to take the conditioning treatment because of some physical contraindication such as a bad heart.

At the present time 30 per cent of our patients are receiving pentothal as well as conditioning treatment.—Lemere & O'Hollaren, Seattle, Wash.; Northwest Medicine, Vol. 48, No. 7, July, 1949.



Obstetrics As Taught at the College of Physicians and Surgeons of Columbus, Ohio (1835-1841). Part I

JONATHAN FORMAN, B. A., M. D., F. A. C. A.

LITTLE has been written about the College of Physicians and Surgeons of Columbus, Ohio, or Botanico-Medical School,* as it was usually referred to by its friends and its founder, Alva Curtis.

Alva Curtis, while living in New Hampshire, had witnessed in his own family, the life of a brother made miserable and cut short by the mercurial treatment so frequently resorted to by physicians of the regular school. This caused him in his embitterment to reject the regular system of practice and therefore, later, about 1830, he embraced the tenets of the Thomsonianism. After graduating from an academy, like many New Englanders, he went south about 1825 and became a teacher in a girls' school in Richmond, Virginia, where he continued successfully for several years. But, as Frederick Waite has pointed out, "When William Lloyd Garrison in 1831 proclaimed his demand for the immediate emancipation (of slaves), Alva Curtis supported the doctrine. This terminated his availability as a teacher in Richmond." Having lost his position as a teacher, he persisted in trying to support himself in Richmond as a practitioner of the Thomsonian system of healing, but his known adherence to abolition made him inacceptable. It seemed wise to move back north where his ideas would be acceptable.

Ohio was in its period of most rapid expansion and growth. Curtis, therefore, chose Columbus where he settled in 1834. Here, he took over the editorship of the *Thomsonian Recorder*, the most prominent and important of the many journals representing this system of healing. He attracted considerable attention as he waged war on four fronts, with the regular physicians, with the Reformed-Botanic and their medical school at Willoughby, with the homeopaths, and shortly with Samuel Thomson himself.

* The Literary and Botanico-Medical Institute of Ohio was the official name used in its incorporation which took place on March 9, 1839, giving the Institute the full powers of a University.

The Author

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Alva Curtis was far above the average Thomsonian in both education and ability. Soon after his arrival in Columbus, he began to instruct students in his own house. As he was a brilliant man and an experienced teacher, he attracted a good many students. In his efforts to secure a charter for his school, however, it was natural that all those with whom he was at war should oppose him. Samuel Thomson deprecated his conduct as being virtual apostasy.

Samuel Thomson insisted that those who bought the patent rights to practice his system of healing had the knowledge necessary to meet every situation. Even the casual reader, however, can see that Thomson's instructions would hardly give a sense of security to the more timid when confronted with the parturient woman who after hours of labor demanded something be done when seeing a sick and dying infant.

It was Curtis' original idea that he might render a volume so that "if a Thomsonian should, through inexperience, fear, in a difficult case, to apply his favorite practice, a reference to its pages would show him that the fundamental principles and most common and important modes of application are advocated and sustained by many of the most learned and judicious authors of the old school; where these same gentlemen

have given to depletion, anti-phlogistic rash, and instrumental system the credit of almost all the mishaps that have ever happened in the chamber of parturition.

Curtis, therefore, wrote out his 18 "Lectures on Midwifery and the Forms of Disease Peculiar to Women and Children," which he delivered to his students at the Botanico-Medical School in the summers of 1835 and 1836; and published early in 1837 (printed by Jonathan Philips for the author).

That Curtis had properly sensed this need for the more inexperienced and more timid of the Thomsonians is evidenced by the fact that the Fifth Convention of the Friendly Thomsonian Botanical Society of the United States passed a resolution cordially approving his proposal to publish his lectures after hearing him deliver a lecture on obstetrics, and sustained this resolution with a very liberal subscription.

An examination of this manual of Alva Curtis will reveal that he has done an excellent job. He set out to give courage to those who must believe that the course of pregnancy was a physiological process, that childbirth was a normal and safe procedure for healthy women. The Thomsonian could meet infection with his "steam and puke" routine as well, if not better than the regular with their huge doses of calomel. He was taught by Curtis to judge by external measurements, to keep his hands out of the vagina, to avoid forceps, and not to attempt to hurry the labor; to keep the midwife from pulling on the after-birth, assuming that sooner or later all of it would come away.

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2. Forman, Jonathan, M. D.: Dr. Alva Curtis in Columbus: The Thomsonian Recorder and Columbus' First Medical School. The Ohio State Arch. & Hist. Quarterly, 1942: 51, 332-341.
3. Forman, Jonathan, M. D.: The Worthington (Ohio) School and Thomsonian. Bull. Hist. Med., 1947:21, 772-787.

The Story Behind the Word: Some Interesting Origins of Medical Terms

Charlatan:—This term derives from the Italian word "ciarlare," meaning empty garrulity, to chatter, or to be a windbag. Without hocus-pocus and chatter, the charlatan is just another man with a tray.

Quack:—An imitative word from the low German "quackelen," to talk much and idly, to work unskillfully. There is, too, the related Dutch word "Kwacken" reflecting the gobble or gibberish of the duck.

Mountebank:—Another name for a quack or charlatan. The word mountebank is mentioned by Stanghurst as early as 1577 and applies to a traveling quack, who from a platform appealed to his audience by means of stories, tricks and jugglings, often assisted by a clown. Literally the term comes from "mounts-the-bench" because they frequently carried a bank or bench with them and mounted upon it to deliver their sales talk.

Panacea:—This term is derived from the Greek word "panakeia," an herb supposed to have the power of healing all diseases. It is derived from the Greek words "pan," all, and "akeomai," to heal or cure.

Placebo:—A Latin term and literally means "I shall please." It is a prescription given by a physician to please rather than to benefit the patient.

Delirious:—This word is derived from the Latin term "de lira," meaning the ridge between two furrows. Literally then the word means deviating from the furrow or straight line.

Gout:—The name Gout is derived from the Latin "gutta," a drop, and owes its origin to the ancient conception that the disease depended upon a peculiar noxa which fell drop by drop into the affected joint.

Remedy:—This word is derived from the Latin "remedium," a cure. It is from the Latin "re," again, and "medeor," I heal.

Tonic:—The term tonic came into our medical vocabulary from the ancient Pythoragean school of philosophers who believed that music would heal the sick, and particularly recommended it for tired minds and jaded nerves. From these tonal treatments of the sick and ailing the word tonic was derived.

Rx:—This symbol is the abbreviation of the Latin word recipe meaning "take thou." The ligature or cross stroke is simply a sign of abbreviation.

Prognosis:—This term is of Greek origin and literally means foreknowledge. It is derived from the Greek term "pro," before, and "gnosis," knowledge.

Hygiene:—This word has descended to us from the Classical Greek Mythology and is named after Hygeia, the gracious Greek Goddess of Health.

Surgeon:—This term comes to us from the French term "Chirugien," which comes from the Latin and in turn derives from the Greek words: "Cheir," the hand, and "ergon," or work. Literally then a surgeon is one who works with his hands.

Orthopedics—Orthopedist:—These terms are of Greek deviation and literally mean "straight child." They are taken from the Greek words "orthos" or straight, and "paideia," the rearing of children.

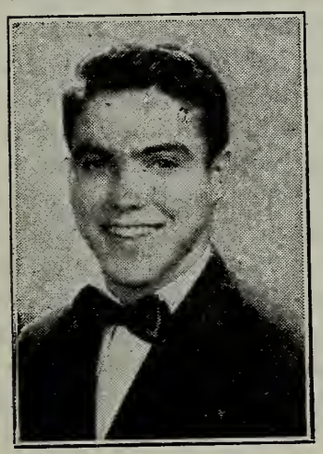
—HARRY WAIN, M. D., Mansfield, Ohio.

Rural Medical Scholarship . . .

Guernsey County Youth Is First Recipient of Association's Award To Stimulate Country Practice; Record Reads Like Who's Who Prospect

THE committee appointed to pick a recipient for the Association's new rural medical scholarship was fortunate in having among applicants for the initial award a young man whose record and outlook fit the requirements to a T.

He is C. Craig Wright, Guernsey County farm youth, who will enter Ohio State University College of Medicine this fall. Under the terms of the scholarship he will receive $500 each year during the four years he is in medical school, provided only that he remain in good standing.



C. C. WRIGHT

The scholarship was created with the idea of encouraging rural young men and women to take up the study of medicine in the hope that they will become country doctors and help supply the needs of Ohio rural areas. An additional scholarship will be awarded each year until the Association is sponsoring four students concurrently at medical schools.

Leadership in rural affairs was a major point in Wright's favor during the judging, according to members of the Association's Committee on Rural Health, which has charge of the selection of candidates, although he has an outstanding scholastic record as well. Wright has served three years as president of his local 4-H Club; has served as a 4-H Junior Leader in Guernsey County; as vice-president of the County 4-H Older Youth Group; and as a Southeastern District 4-H Camp councilor.

He is a past-president of the local Farm Bureau Youth Council; is a past-president of the Young People's Society of the local Christian Church, as well as Sunday School superintendent and choir director; and has served as a Scout patrol leader and as chairman of the Dairy Division of the Ohio State Junior Fair.

Wright's record in premedical school is outstanding, with a 3.7 point-hour average out of a possible 4.0. Selection committee officials, however, pointed out that they were impressed by the fact that this scholastic rating was achieved in spite of a heavy load of extra-curricular activities.

While attending Ohio State University he was president of Lambda Chi Alpha, social fraternity; a Student Senator for two years; Sophomore Class president; president of the Freshman Fraternity Council; secretary of the Interfraternity Court; secretary of the Fraternity Affairs office; member of the University 4-H Club; and of Alpha Epsilon Delta premedical honorary fraternity.

He was elected to Phi Eta Sigma, freshman honorary fraternity; and Romophos, Bucket and Dipper, and Sphinx, the sophomore, junior and senior men's campus leadership societies. He was a member of Ohio Staters, Inc., the Freshman fencing team, and was the recipient of the Dr. L. L. Bigelow Memorial Premedical Scholarship.

Wright earned about half of his premedical school expenses working on the 200-acre dairy farm operated by his father, and by custom hay baling with a rig which he bought on a loan two years ago.

The son of Mr. and Mrs. Thomas Wright of Winterset, he was an "all A" student at Madison Rural High School; president and valedictorian of his high school class; captain of the basketball and track teams; and was active in the school music and drama organizations. He placed second in biology in the state scholarship tests while in high school.

Drs. Portmann and Clement Head A. M. A. Specialty Sections

Two Ohio physicians were honored by being elected chairmen of specialty sections at the annual session of the A. M. A. in Atlantic City.

Dr. U. V. Portmann of Cleveland, was elected chairman of the Section on Radiology. He has served as vice-chairman and secretary of the section. He is a past-president of the Ohio State Radiological Society and of the Cleveland Radiological Society and is president-elect of the American Roentgen Ray Society. Dr. Portmann is head of the Department of Therapeutic Radiology at the Cleveland Clinic.

Dr. Fred Clement, Toledo, was elected chairman of the Section on Anesthesiology. Dr. Clement has been a pioneer in anesthesiology in Ohio and has been very active in national organization work. He has served as a director and as vice-president of the American Society of Anesthesiologists.

Principles of Medical Ethics . . .

Significant Changes in Regard to Contract Practice, Education of Public, Rebates, Made in Revision by A. M. A. House of Delegates

OF paramount significance to the medical profession is a matter which was handled almost routinely at the Annual Session of the American Medical Association and was overshadowed by more spectacular events of the meeting. This was approval by the House of Delegates of a restatement and revision of the Principles of Medical Ethics, accomplished after exhaustive study by the Judicial Council of the A. M. A.

Although the preamble states that "these principles are not laws to govern but are principles to guide to correct conduct," their place in shaping the actions of physicians and the medical profession as a whole are too well known to be enlarged upon here.

VOLUNTARY SUBJECTION

The *Journal of the A. M. A.* points out that in the case of the Government versus the American Medical Association tried in Washington in 1941, the courts took cognizance of the Principles of Medical Ethics as a guide to physicians in relationship to the adoption of any methods of medical practice. The Courts recognized that members of the A. M. A. voluntarily subjected themselves to the stipulations of the constitution and by-laws of county and state societies, of the A. M. A. and also of the Principles of Medical Ethics.

Many statements of the former version of principles have been carried over to the revision, but, on the other hand, many sections, although changed only slightly in wording, have been given new significance. Any attempt to interpret the changes or even to attempt to point out all of the significant changes at this early date would be presumptive. Each physician should read the revised Principles and digest their content. They will be found on pages 700 to 703, inclusive, of the June 25 issue of the *Journal of the A. M. A.*

Shortly the Principles of Medical Ethics will become available in the form of a newly designed booklet which may be secured from the office of the secretary of the A. M. A.

SIGNIFICANT CHANGES

The *Journal of the A. M. A.* further points out that the most significant changes are those relating to groups and clinics, including contract practice, the section on education and information and the section on the purveyal of medical service. The elaboration on the subjects of rebates is pertinent.

The *Journal of the A. M. A.* further points out editorially that the report of the Committee on Hospitals and the Practice of Medicine took its guidance from the Principles of Medical Ethics as last revised in 1940 rather than from the new statement which was adopted in this 1949 session. "No doubt further considerations by this committee in the period between now and the Clinical Session of the Association which will be held in December will result in coordination of these actions," the editorial observes.

"The fundamental principle that the physician shall not dispose of his professional attainments or services under terms or conditions which permit exploitation of the services for financial profit of a corporation or lay agency still holds," the editorial continues. "The only type of contract practice specifically condemned is that which may result in deterioration of the quality of the medical services rendered."

The section on contract practice reads as follows:

CONTRACT PRACTICE

> Sec. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision, or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.
>
> Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

The section on purveyal of services is as follows:

PURVEYAL OF MEDICAL SERVICE

> Sec. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

Among the most important changes and additions are those related to education of the pub-

lic regarding health and disease and dissemination of information to the public regarding medical affairs in general. The Principles previously covered this aspect of medical relations to the public under the statement on advertising. The statement in regard to advertising in the revision is basically the same as formerly, but the following significant statement is made in regard to educational information:

EDUCATIONAL INFORMATION NOT ADVERTISING

Sec. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

The subject of rebates formerly referred to briefly under the section on patents and perquisites has been enlarged upon considerably as follows:

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

Sec. 6—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a coypright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

Important Correction In New V. A. Fee Schedule

There was one error in the new Veterans Administration Medical Fee Schedule which became effective August 1, a copy of which was sent to each member of the Ohio State Medical Association with the July 27 *OSMAgram*.

Item No. 0056 should have read "Other comparable specialties not listed above: Each subsequent visit $3.00" (instead of $5.00).

Please clip out this box and paste it in your copy of the fee schedule or correct your copy of the fee schedule.

Each physician who handles Veterans Administration patients should preserve the copy of the fee schedule sent to him. It contains a number of important changes. Don't mislay your copy as only a limited number of extra copies are available at the Columbus Office of the State Medical Association which had the copies printed at its own expense for distribution to participating physicians and to all offices of the Veterans Administration.

The 14th Annual Meeting, Mississippi Valley Medical Society, will be held at the Jefferson Hotel, St. Louis, Sept. 28, 29, 30, under the Presidency of Dr. Alphonse McMahon, Associate Prof. of Medicine, St. Louis University.

More Hospital Jobs Approved . . .

Two Chronic Disease Units Are Added to Construction Projects for Participation in Federal Funds; 27 Projects Now on Approved List

CONSTRUCTION of two chronic disease hospitals with a total bed capacity of more than 850 patients has been approved for participation under the Federal Hill-Burton Law, Anthony J. Borowski, Dr. P. H., administrator of the plan under the Ohio Department of Health, has announced.

The Chronic Disease Hospital of Hamilton County with a bed capacity of 414 has been approved and construction is expected to get under way within a matter of weeks. Total estimated cost of construction is $4,331,000 of which the Federal government's share will be $977,000.

The Cuyahoga County Chronic Disease Hospital will have a capacity of approximately 440 beds. Total estimated cost is $5,829,400 of which the Federal government will supply $829,400. The hospital will be built in conjunction with the present Cuyahoga County Tuberculosis Hospital at Warrensville.

The chronic disease hospitals are two of the most extensive projects approved for participation in Federal grants-in-aid under the provisions of Public Law 725 (Hill-Burton Law). Approval of the projects is in keeping with the required policy of the Hospital Facilities Office that an appropriate balance be maintained in types of hospitals accepted.

FOUR NEW PROJECTS

The two projects come under the third year's program which began July 1, 1949, and will end June 30, 1950. Four additional projects also have been approved for the third year and approval of others is pending.

The four recently approved projects are as follows:

Williams County Joint Township Hospital, Montpelier, is still in planning stage. Plans call for 25 beds and 11 bassinets. Total cost is estimated at $550,000 of which the Federal government will contribute $183,333.33.

Brown County Hospital, Georgetown, 42 beds; total estimated cost $600,000 of which the Federal share will be $200,000; still in planning stage.

Molly Stark Sanitarium, Canton; an increase of capacity of approximately 100 beds to bring the total capacity to 240 beds; estimated cost $750,000—Federal share $250,000; still in planning stage.

Marietta Memorial Hospital, Marietta; addition of 50 beds to existing hospital; estimated cost $600,000; Federal share $200,000; still in planning stage.

FIRST TWO YEARS

The new approvals bring to 27 the number of Ohio hospital projects accepted under the plan to date. Twenty-one projects previously were announced for the first two years of the plan.

Following is a list of the projects approved under the first two years, in the order in which they appear in the records of the Hospital Facilities Office, showing progress to date and other data, including adjusted estimates on final cost in some instances:

Memorial Hospital of Fayette County, Washington C. H., general hospital and health center; 34 beds, 15 bassinets; county sponsored; $630,000; construction began in March.

Greene County Hospital, Xenia; general with outpatient department and public health center; 75 beds, 27 bassinets; county sponsored; $1,356,678.68 (Federal $440,559.56); construction now under way.

Ashtabula General Hospital, Ashtabula; general hospital with outpatient department (replacement of existing hospital plant); 109 beds, 25 bassinets; N. P. A. (non-profit association); $1,786,218 (Federal $595,406); now under construction.

Mount Saint Mary Hospital, Nelsonville; general hospital with outpatient department and public health center; 74 beds; 15 bassinets; nonprofit association (church); $1,256,965.88; construction well under way and expected to be substantially completed during 1949.

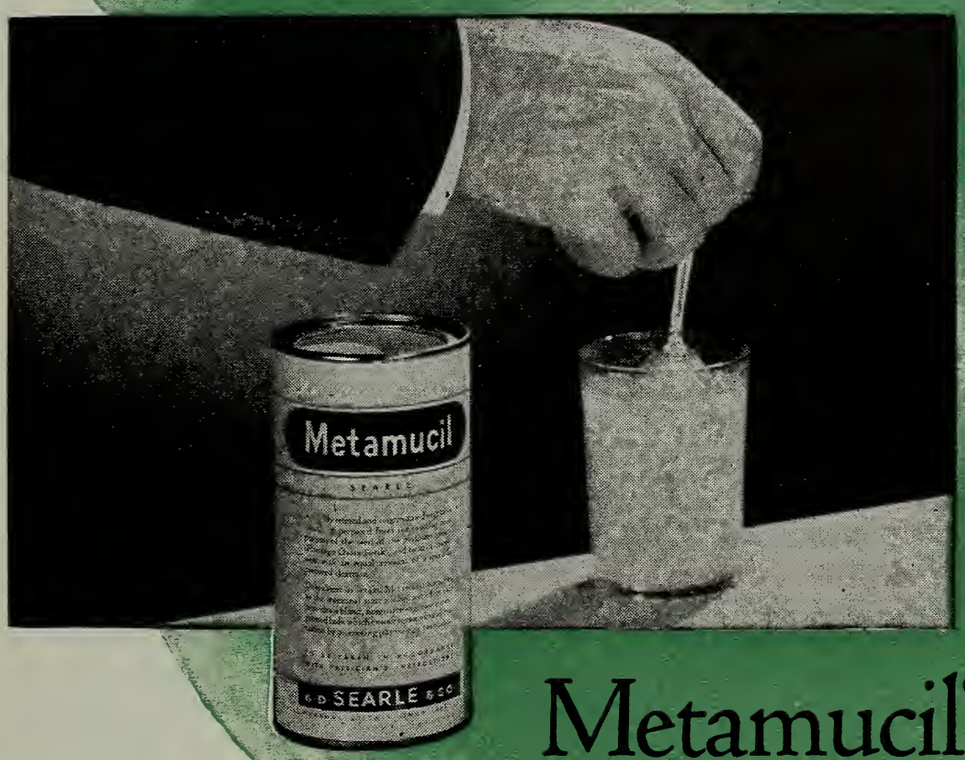
Defiance Hospital, Defiance; general with outpatient department and public health center; 49 beds, 22 bassinets; city sponsored; $897,910.62 (Federal $299,303.54); approved in June; construction under way.

Clinton Memorial Hospital, Wilmington; general hospital; 65 beds, 28 bassinets; county; bids again have been take on this project.

Mercy Memorial Hospital, Urbana; general hospital (church); 50 beds, 21 bassinets; $858,000 (Federal $286,000); plans completed; bids were scheduled to be opened late in August.

Richland County Tuberculosis Sanitorium, Mansfield; tuberculosis sanitorium with outpatient department; 84 beds; county; $788,025.58.

A "soft matrix for bulk for the stools"*



Metamucil®

Principles ascribed by this author* to Metamucil—the "smoothage" management of constipation—are:

... demulcent action
... ability to absorb and hold water
... nonirritating to the intestinal mucosa
... providing a soft matrix for bulk in the stools

Metamucil promotes smooth, normal evacuation by furnishing a nonirritating, water-retaining colloidal residue in the large bowel.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

G. D. Searle & Co., Chicago 80, Illinois.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Searle

Research in the Service of Medicine

*Gauss, H.: Present Trends in Mucous Colitis, Am. J. Digest. Dis. 13:213 (July) 1946.

Construction well advanced and expected to be completed before end of year.

Mary Rutan Hospital, Bellefontaine; general 34-bed addition to existing hospital; 75 beds, 27 bassinets; city; $438,221.82; construction well advanced.

Brown Memorial Hospital, Conneaut; general 35-bed addition to existing hospital; 60 beds, 16 bassinets; N. P. A.; $561,240 (Federal $187,080); now under construction.

Wood County Hospital, Bowling Green; general with provisions for additions for outpatient department and health center; 54 beds, 21 bassinets; $839,766.64 (Federal $279,922.21); now under construction.

Union Hospital, Dover; general with public health center combined; replacement; 97 beds, 38 bassinets; N. P. A.; $939,609.56; still in planning stage.

St. Joseph Hospital, Lorain; general, addition of 68 beds to existing hospital; 194 beds, 50 bassinets; N. P. A.; $725,527.24; now under construction.

Wooster Community Hospital, Wooster; general and public health center; 70 beds, 21 bassinets; publicly owned; $1,369,986.66; construction well advanced.

Guernsey Memorial Hospital, Cambridge; general with provision for public health center on alternate bid; 66 beds, 22 bassinets; N. P. A.; $1,050,000; still in planning stage.

Wyandot Memorial Hospital, Upper Sandusky; general; 25 beds, 10 bassinets; N. P. A.; $394,984 (Federal $131,661.33); approved in June; now under construction.

Union County Memorial Hospital, Marysville; general and community health center; 25 beds; 12 bassinets; publicly owned; $525,000 (Federal $175,000).

Memorial Hospital of Geneva, Geneva; general; 24 beds, 12 bassinets; N. P. A.; $399,509 (Federal $133,169.66); under construction.

Harding Memorial Hospital, Kenton; general; 44 beds, 8 bassinets; N. P. A.; $540,000; construction started before project was brought under Hill-Burton Law; final plans being completed.

Elyria Memorial Hospital, Elyria; general addition of 80 beds to existing hospital; 177 beds, 33 bassinets; N. P. A.; $1,411,000; still in planning stage.

Chillicothe Hospital, Chillicothe; general, addition of 51 beds to existing hospital, possible health center; 106 beds, 26 bassinets; N. P. A.; $975,000; still in planning stage.

Sister Elizabeth Kenny recently relinquished administration of the polio foundation which bears her name and was succeeded by Dr. E. J. Huenekens of Minneapolis, Minn.

Effective Dates of Certain Laws Enacted by Legislature

Listed below are the effective dates of certain laws enacted by the 98th Ohio General Assembly which are of special interest to physicians:

Senate Bill 26, providing for a fee of 50 cents for issuance of certification of birth. **Effective July 5, 1949.**

Senate Bill 22, placing isonopecaine (demerol), amidone (methadon, dolophine, adanom), isoamidone and keto-bemidone within the provisions of the State Narcotic Control Law. **Effective September 8, 1949.**

House Bill 75, requiring enrichment of flour and bread with vitamins and minerals. **Effective July 13, 1949.**

House Bill 308, controlling the sale and distribution of barbiturates. **Effective August 12, 1949.**

House Bill 446, creating a commission to study the problems of chronic alcoholism and to advise regarding state institutions for alcoholics. **Effective October 14, 1949.**

Senate Bill 129, increasing power of Director of Public Welfare. **Effective October 20, 1949.**

Senate Bill 188, providing for payment of services to recipients of aid for the aged in outpatient departments of hospitals. **Effective October 18, 1949.**

House Bill 277, general revision of state poor relief law. **Effective October 20, 1949.**

House Bill 470, providing that collections in excess of $5.50 a week from families of patients in state hospitals shall be placed in rotary fund for mental hygiene research activities. **Effective October 7, 1949.**

House Bill 493, providing easier and quicker method for temporary commitment of mentally ill person. **Effective September 26, 1949.**

Senate Bill 60, anti-stream pollution law. **Effective August 25, 1949.**

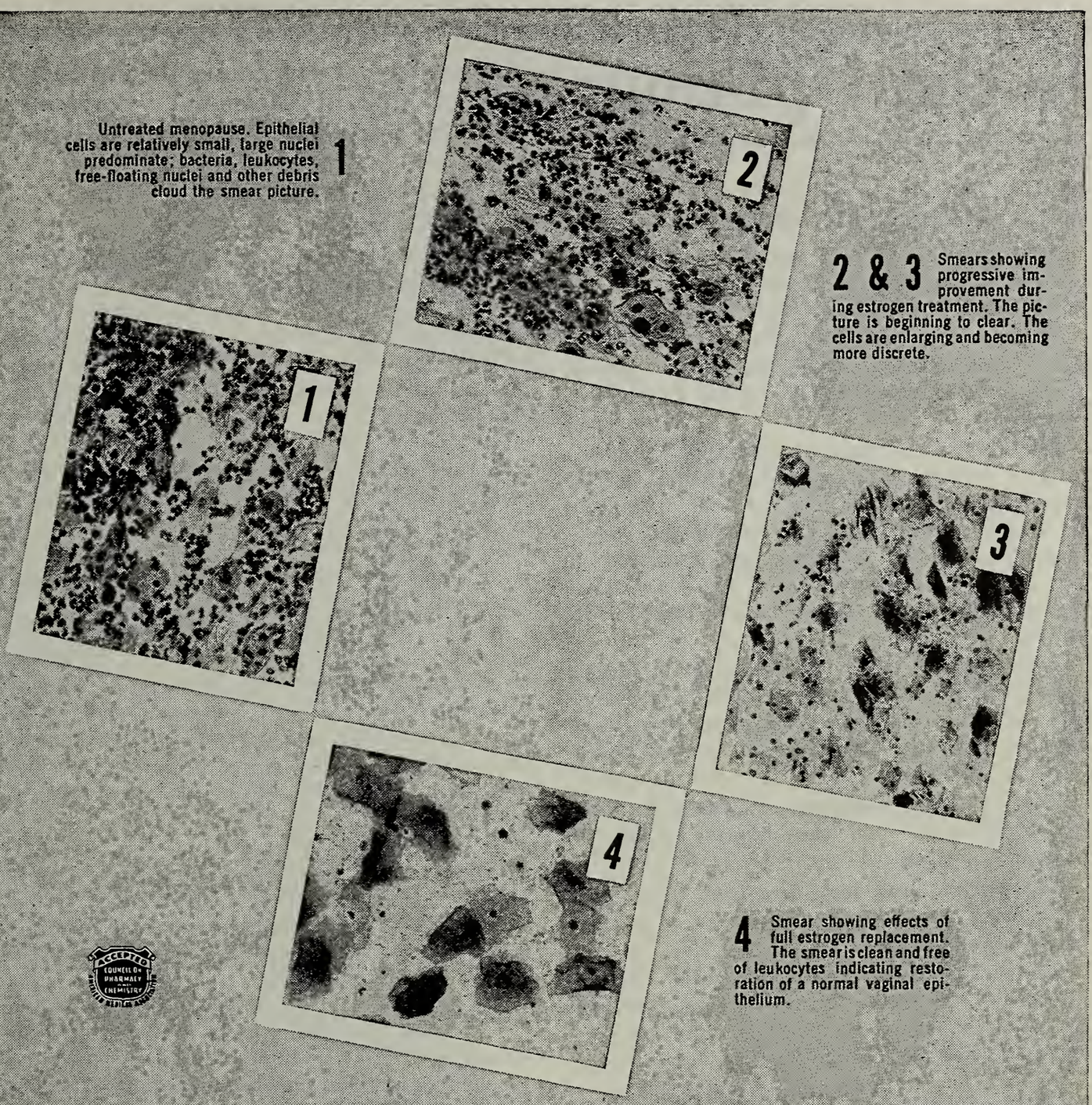
Senate Bill 134, providing for a commission to study compulsory disability insurance. **Effective August 25, 1949.**

House Bill 531, agreed Workmen's Compensation bill, increasing the weekly compensation, maximum death benefits, etc. **Effective September 1, 1949.**

Public Health Association

The Executive Board of the American Public Health Association announces that the 77th Annual Meeting of the Association and meetings of related organizations will take place in New York City, October 24-28. The Hotels Statler and New Yorker are joint headquarters.

Approximately 28 related organizations will hold meetings at the same time and place.



1 Untreated menopause. Epithelial cells are relatively small, large nuclei predominate; bacteria, leukocytes, free-floating nuclei and other debris cloud the smear picture.

2 & 3 Smears showing progressive improvement during estrogen treatment. The picture is beginning to clear. The cells are enlarging and becoming more discrete.

4 Smear showing effects of full estrogen replacement. The smear is clean and free of leukocytes indicating restoration of a normal vaginal epithelium.

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ESTROGENIC SUBSTANCES

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For action with little or no side action in control of menopause and certain other ovarian disorders.

CONESTRON, a complex of estrone, estradiol, equilin, equilenin and hippulin in the physiological conjugate obtained from the pregnant mare, supplies estrogens from natural sources, in the original, orally active form.

Conestron therapy produces a sense of well-being and is almost completely devoid of side reactions. Given in small, frequent, oral doses, Conestron permits a more uniform rate of absorption and maintains an effective level of blood estrogens.

Tablets of 0.625 and 1.25 mg., expressed as estrone sulfate. Bottles of 100 and 1000.

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WYETH INCORPORATED, PHILADELPHIA 3, PA.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

OHIO DOCTORS LAGGING ON A. M. A. ASSESSMENT PAYMENTS

Approximately 60 per cent of the members of the Ohio State Medical Association had paid the A. M. A. $25.00 assessment as of August 15.

That's a poor and disappointing batting average. Compared to the other state medical societies, Ohio ranks in 34th position in payment percentage.

There may be a small percentage of physicians in Ohio who care nothing about medical society activities, who don't give a hang what the public thinks, or who aren't at all concerned about present-day social trends. But, surely 40 per cent of the members of the Ohio State Medical Association do not fall in these categories.

Doubtless, the poor record in Ohio is largely the result of apathy, neglect or lack of knowledge of the necessity for the nation-wide educational campaign for which the A. M. A. assessment is being used.

Those who are apathetic may wake up some fine morning to find the private practice of medicine in ruins.

Those who have just forgotten to send in their check may find that tomorrow is too late to lock the barn door.

Those who claim they don't know what its all about are either trying to kid somebody or they haven't been reading the monthly issues of *The Ohio State Medical Journal.*

Those who would like to see drastic changes made in the practice of medicine—changes which are questionable in the minds of many—would be expected to be unsympathetic with the A. M. A. program. It is understandable why they have not paid the assessment.

There is no way to divide up the list of unpaids into these categories. All the record can show is that you have paid: you have not paid.

On which list is your name?

Officials of the Ohio State Medical Association have not used the "big stick," believing that most Ohio physicians are aware of the vital issues and realize that the medical profession's public educational campaign is necessary and desirable. They have left it to each individual physician to act. It would seem to be high time for those who have not paid the assessment to act. By sending in your check at once, you can help to boost Ohio to the top flight among the state societies—where it belongs.

CONGRATULATIONS TO C. CRAIG WRIGHT

Through *The Journal,* the officials of the Ohio State Medical Association officially and publicly congratulate C. Craig Wright, Winterset, Guernsey County, the 1949 winner of the Ohio State Medical Association Rural Medical Scholarship. Wright, a 20-year-old farm lad, has an outstanding high school and college record; spent most of his life in rural communities; and wants to establish a practice in a rural area after completing his medical training. It is hoped he will establish a record in medical school at Ohio State University which will qualify him to continue to receive the $500 annual award during all four years of medical school.

Wright's performance will be watched with interest. If he turns out to be the physician he should, and establishes himself in some small community where he can make an equally good record in active general practice, the expenditure of $2000 by the State Association to assist him through medical school will certainly be justified.

Another scholarship of $500 will be awarded in 1950; another in 1951; and another in 1952, until the Association will be aiding four worthy students from small communities, who have expressed a desire to practice in rural or semi-rural communities.

The project is a tangible demonstration on the part of the State Association of its sincere interest in doing something toward meeting the problem of adequate medical personnel for the rural areas of Ohio. It alone will not solve the problem. Nevertheless, it's a start and should stimulate additional interest and action.

PLAN TO ATTEND THE SAFETY CONFERENCE

Elsewhere in this issue will be found a news story regarding the Ohio State Safety Conference, September 20-22, Hotel Carter, Cleveland. Of significance is the fact that the Committee on Industrial Health and Workmen's Compensation of the Ohio State Medical Association is officially participating in the conference. It is presenting the program of the Medical Section to be held at 2:00 p. m. on Wednesday afternoon, September 21. Four outstanding out-of-state guest speakers have been secured.

Physicians throughout Ohio who are directly or indirectly interested in industrial medicine—especially the members of the Committees on Industrial Health of the county medical societies



Essential food factors

Several decades ago, vitamins, minerals, and other noncaloric but useful components of the diet were known as "accessory food factors." Today, it is recognized that these *accessory factors* are in fact *essential factors*.

Hypernutrition aids the recovery process and tends to hasten tissue repair. Vitamin A, vitamin D, thiamine (B_1), riboflavin (B_2), niacinamide, ascorbic acid (C) and folic acid have enjoyed wide usage for convalescent and reparative states.

Lederle has consistently advocated such use of the vitamins.

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—should make a special effort to attend the Medical Section meeting on September 21. Also, they should plan to take in other sessions of the conference as many of the subjects which will be presented are right down the alley of the physician whose practice has any connection with industry, safety programs, etc.

COMMUNITY CHEST EFFORTS DESERVE SUPPORT OF PHYSICIANS

Citizens soon will be offered an opportunity to lend their active support to their Community Chest Campaign, at least to make a contribution to the Chest and through it to its many community services.

The decision as to whether or not an individual lends his support, obviously, is between him and his conscience. Probably the great majority of doctors in Ohio support the Community Chest. Perhaps there are a few who choose not to support it. That is for each physician to decide for himself. However, doctors should deliberate very carefully before they pass up an opportunity to take part in this community enterprise.

The Community Chest with all of its branches was evolved out of recognition of needs in the community. It started small and has developed into a nation-wide effort. It has grown and prospered because individuals (among them many physicians) recognized needs and stepped in to do something about them.

Health activities are important parts of the community chest program. Physicians and others with special knowledge should have a part in directing these activities.

That the Chest is doing an efficient job is indicated by the report that about seven per cent of contributions are budgeted for administration and campaigning. This is a nominal proportion. Contrast with it the cost of administering any government agency engaged in similar work. According to the Hoover Commission, the Federal Government does $10 worth of paper work for every purchased article—even a $1 water pitcher for a veterans' home. Ninety-three per cent of Community Chest funds find their way to the causes for which the contributions were intended.

There is more to actively or passively supporting a community project than the mere effort itself. Whether or not the doctor wishes to think of himself in that light, he is a leader in the community. The very nature of his profession sets him apart and places him in the public eye. His strictly private life is limited by the fact that people take notice of his every act—whether of commission or omission.

The time a physician contributes to community projects, or the contribution he makes, may be a real sacrifice or it may be merely a philanthropic act. But the good will that he creates by doing his part may far exceed the effort or the gift itself. There is a great deal of give and take in the procedure of gaining good will, and the medical profession needs all the good will it can muster at the present time.

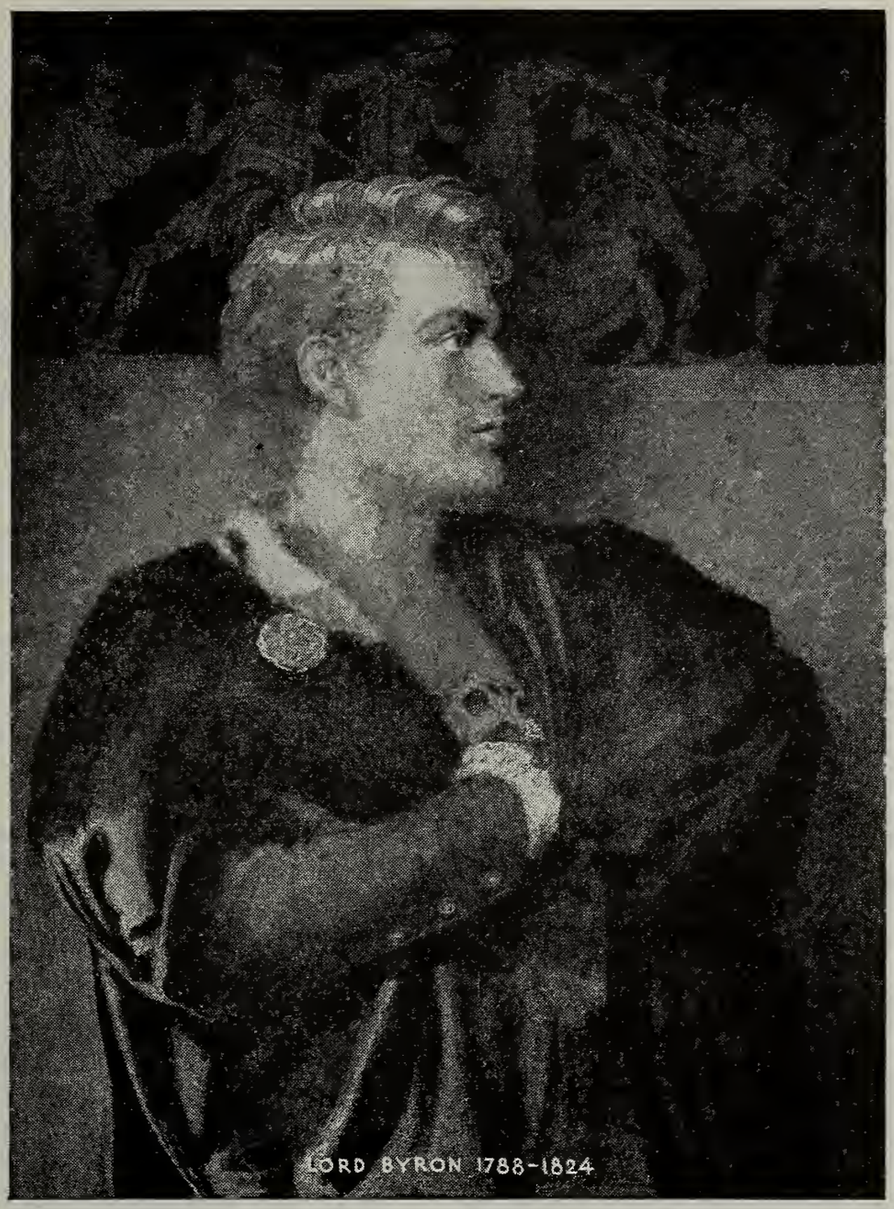
Luncheon club officers, women's organization leaders, farm organization workers, labor groups —all will be taking part in the coming Community Chest drives. These leaders will notice whether or not the doctors as groups or as individuals take part.

The butcher, the baker, the electric light maker, all will be doing their part in putting the Community Chest over the top. Here's hoping there will be no reason for anyone to ask: "What's the matter with the doctors?"

HAVE YOU AND YOUR SOCIETY FOLLOWED THROUGH?

When the 1949 Ohio State Medical Association membership cards were mailed to members, each card was accompanied by a folder entitled "This Is No Time for New Deal Jitters." The folder contained some suggestions for work to be done by county medical societies and individual physicians, offered by Dr. A. A. Brindley, then president of the State Association. Those suggestions were:

1. **Back to the limit the activities of Ohio's voluntary prepayment medical and hospital care plans** (Ohio Medical Indemnity and the Blue Cross Plans). Become a business-getter for these plans . . . deal fairly and squarely with them and their subscribers. They're a powerful argument against the need for governmental schemes.
2. **Make the "25-Point Health Program" of our own State Association a reality** . . . It can do the job in Ohio.
3. **Furnish leadership, guidance and help to organizations in your community** sponsoring sound health programs . . . lip service isn't enough. The people want action from the medical profession . . . not just words.
4. **Take the lead in seeing that Ohio's state and local public health departments are revamped . . . modernized . . . adequately financed,** by Ohio . . . not by Washington. Physicians ought to fight for this.
5. **Put some real punch into the special projects of your State Association** by taking local action. For example: the Rural Health Program and the School Health Program . . . there are others which could be mentioned. Some local societies haven't even named a committee to head up these activities. Help the people solve their own problems.
6. **Put "public relations" on your "must" list.** Be honest, sincere and conscientious in dealing with your patients . . . get into community activities . . . accept speaking engagements . . . tell the people what the medical profession stands for . . . why crack-pot schemes are harmful.
7. **Keep posted on legislative proposals** . . . state and national. Get acquainted with your representatives to Congress and the Ohio Legislature . . . give them your views on pending issues. A handful of committeemen can't do



★ *Epileptic Men of Genius* ★

The brilliant English poet, Lord Byron, who had many mild convulsive attacks during his short life, is an outstanding example of the fact that epilepsy need not cloud a man's mentality.

Comparative studies have shown that in some cases better control of grand mal as well as petit mal seizures can be obtained with Mebaral than with corresponding doses of other antiepileptic drugs. Mebaral produces tranquillity with little or no drowsiness. It is particularly desirable not only in epilepsy but also in the management of anxiety states and other neuroses. The fact that Mebaral is almost tasteless simplifies its administration to children. Average dose for children ½ to 3 grains, adults 3 to 6 grains daily. Tablets ½, 1½ and 3 grains.

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the job adequately. Passage or defeat of bills depends on how many folks back home are for or against them.

8. **See that your county medical society . . . large or small . . . is something more than just a name . . . a paper organization.** Insist that it receives alert, competent leadership . . . becomes active in and provides competent guidance for community health activities . . . takes a firm stand on legislative issues . . . has hard-working committees . . . conducts itself so as to win the respect, good will and confidence of the community. To be of any help, you will have to attend meetings . . . assume responsibilities . . . serve on committees.

The point of this comment is to inquire from you and your county medical society:

Have you followed through on any or all of these recommendations?

Has your county medical society done likewise?

If not, it is high time for you and your society to get busy.

SEE YOUR CONGRESSMAN WHILE AT HOME

Here is a suggestion from the *Pubic Relations Reporter* of the Pennsylvania State Medical Society which, if followed, can be just as beneficial in Ohio as in the Keystone State. How about doing something along this line?

"Congress will soon be adjourning and your Representative will no doubt use this time to sound out the sentiment of his constituency on current legislation. Don't miss this opportunity to personally contact your Senators and Representative and explain to them why your county medical society opposes compulsory sickness insurance. Medicine's position should be clearly explained and an expression of his position on this most vital issue solicited. Wouldn't it be a good idea for the representative's home county medical society to invite the other county medical societies within their congressional district to a meeting and have their congressman speak to them on health legislation now before Congress?"

TAXES, POWER AND LOCAL RESPONSIBILITY

Physicians are taxpayers—most of them generous ones. For that reason, they should be concerned at current trends.

Senator Taft, Ohio, recently pointed out to the U. S. Senate: The Federal, state and local governments are collecting about $55 billion in taxes which is about 25 per cent of the 1948 national income.

At a recent committee session in the Congress, the testimony revealed: While Federal tax collections in 1932 amounted to a little more than one-fifth of the taxes levied in the U. S., that by 1947 the Federal share had increased to three-fourths of the total collected. This led one witness to remark that the shift of tax dollars threatens to starve the local and state governments out of existence; is "weakening local responsibility, curtailing civilian participation in government, undermining our democratic processes, and leading straight toward establishment of a national government in place of our Federal system of states."

These statistics clearly show why the state and local governments have had to go to Washington with their hands out for money to do a lot of things that can best be done by governments closer to the people.

Yet, nobody seems to be doing anything about it.

Take a look at the record of the Ninety-Eighth Ohio General Assembly which just adjourned. At the demand of the Governor, it refused to vote appropriations exceeding the estimated income of the state for the biennium. On the surface that would appear to be sound financing. However, some of the important departments of the state are still going to be required to get and use more Federal money to keep their programs in operation. The health department is one. As long as this situation continues, there can be little hope of a reduction in Federal taxes or a correction of the dangers pointed out at the beginning of these comments.

So far as we know, no efforts have been or are being made to screen the various state departments to find out whether the services they are performing are necessary or whether some of them could be dispensed with or curtailed, thus saving tax money.

Thus, we have right here in Ohio a confusing situation. Those in the driver's seat show no disposition to want to cut down on government activities or, to put it another way, to sort out government activities, increasing emphasis where emphasis is necessary and de-emphasizing those activities which are of less importance. At the same time, they refuse to put Ohio on a self-supporting basis, leaving it to Uncle Sam to foot a large part of the bills incurred by some of the departments. By doing so, they please interests who are always crying against new taxes and government costs. They make it appear as if they are operating economically. However, they are playing right into the hands of those who want the Federal Government to take over all responsibilities for government. They are making it almost impossible for the Congress to reduce Federal taxes and expenditures even if it had the desire and courage to do so.

As long as this buck-passing goes on, the taxpayer is going to have less and less to say how and where his tax dollars are spent. Also, he will undoubtedly be squeezed harder as Washington is a lot farther away from the electorate than Columbus or Podunk.

The time has arrived when Federal, state and local officials must go into a huddle on this problem, one of the most serious confronting the

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Normal function without anxiety, fear or devices—plus patient-cooperation.

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country today. Areas of responsibility must be re-defined. There must be a shift of taxing authority away from Washington to the states and local communities. The Federal Government must follow the recommendations of the Hoover Commission and other competent agencies as to how it can operate more economically and efficiently. The states and local communities must take inventory, abolishing or curtailing unnecessary and over-emphasized activities and improving those services from which the greatest dividends accrue.

The course which government will take in this country will depend to a large extent on how this situation is met and settled.

YES, HISTORY CAN REPEAT ITSELF

Does history repeat itself?

Remember about the so-called benevolent kings . . . and their henchmen who kept local conditions "in line?" Also included in this political setup, as you will recall, was a poor chap called the serf. The serf "kicked in" the fruits of his labors to the system, and in return his "needs" were administered according to the whims of the feudal lord.

There are those today who are advocating a return to this scheme of life, perhaps in a modified form at first, but ultimately involving complete serfdom, as taxes become more and more confiscatory, so that more and more privileges and responsibilities of the individual may be assumed by the government.

Does history give you the shivers? If so, start shivering. Also, you'd better register to vote while you still have a vote.

C. N. H. WINS PRIZE FOR HITTING BELOW THE BELT

Chat Patterson, executive director of the Committee for the Nation's Health, ardent advocate of compulsory political medicine, wins the prize for hitting below the belt.

At the opening session of the recent Detroit convention of the National Medical Association, national medical society of Negro physicians, Patterson, sharing the platform with Dr. George F. Lull, secretary of the American Medical Association, intimated: (1) That the American Medical Association is throttling attempts to improve the health of the Negro citizens of the United States; (2) that the A. M. A. is opposing anti-racial discrimination programs, anti-poll tax legislation, and anti-lynching proposals.

You may use your own judgment regarding the label which should be tagged to Mr. Patterson and his allegations.

That's the breed of pups the medical profession is up against, gentlemen. Those are the kind of tactics which are being used by the Committee for the Nation's Health in its "educational" campaign to sell Congress and the people on compulsory sickness insurance.

Here is more convincing evidence why the medical profession is in for the fight of its life —now and in 1950; why the A. M. A. has asked its members for a nominal per capita contribution of $25.00 with which the tools can be forged to fight false, deceptive, and misleading propaganda of the brand being put out by Patterson and his cohorts.

The issue involved should be fought out on its merits. There is no place for questions of racial prejudice and discrimination which the C. N. H. has seen fit to raise.

INDEX TO ADVERTISEMENTS AGAIN APPEARS IN THE JOURNAL

In this issue of *The Journal* the Index to Advertisements is resumed after having been dropped temporarily during the war with other curtailments.

Like the advertisements to which it refers, this index is a two-sided proposition. It helps the advertiser by drawing attention to his message, and it helps the physician by giving him a means of quickly locating the announcements of his favorite supply houses.

Many physicians find that by following the advertising themes of pharmaceutical manufacturers and others who supply the medical profession they add measurably to their cumulative store of scientific information.

The Index to Advertisements usually will be found on the page facing the classified advertising page in the back of the issue.

HOW DOES YOURS STACK UP?

Have you checked up recently on your reception room, Doctor?

That's an important element in your practice; in your relationship with your patients.

At least that's what the *Public Relations News* says about reception rooms in general. So, the physician's reception room must not be an exception. Here's what the public relations magazine has to say:

"First place to start your public relations indoctrination may be in the executive offices but the first place to begin worrying about the impression you make on the public is in your reception room. A high proportion of visitors get unfavorable impressions, not only from the way they are treated, but also from the physical appearance and equipment of the reception room. Not only should it be equipped for comfortable and friendly hospitality, but it should in every way possible reflect the character of the organization."

Perhaps it's time for you to take an inventory, then make your reception room more presentable, if the inventory indicates.

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Elixir Mesopin permits the administration of a proven gastrointestinal antispasmodic—highly selective in its action—in a liquid form. It may be prescribed alone or in combination with many other commonly used drugs.

In digestive tract pain due to spasticity and hyperactivity, Mesopin provides prompt relief with virtual freedom from the undesirable side effects of atropine and belladonna. Effective relief of gastrointestinal spasticity may be obtained in such conditions as peptic ulcer, dyspepsia, flatulence, biliary disease, and constipation.

Supplied on prescription in 16-ounce bottles, each teaspoonful contains 2.5 mg. Mesopin, the equivalent of one Mesopin tablet.

Dosage: Adults, one to two teaspoonfuls; Infants, 15 to 20 drops.

Mesopin Tablets (2.5 mg.) also available.

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New Water Pollution Law Has Teeth . . .

Department of Health Is Making Survey To Determine Treatment Necessary To Make Sewage and Industrial Wastes Non-Polluting

ON August 25 Ohio's newly enacted legislation on stream pollution control went into effect, but before this date the Ohio Department of Health had begun a survey to determine to what extent sewage and waste products must be treated before they can safely be dumped into surface streams.

The new pollution law provides for a fine of up to $500 for each 30-day period in which a political subdivision, public institution or industrial plant dumps untreated sewage or waste into any stream. Time is allowed, however, for municipalities and plants to install necessary equipment and otherwise adjust to the new provisions. Health authorities estimate that several years will be required before all provisions of the legislation can be put into effect.

The act, known as Public Law 845, reads as follows:

"Be it enacted by the General Assembly of the State of Ohio:

"SECTION I. That supplemental section 1240-4 of the General Code be enacted to read as follows:

"Sec. 1240-4. It shall be unlawful for any city, village, county, or other political subdivision, public institution, corporation or officer or employee thereof, or other person to maintain or permit to be maintained sewers for the discharge of sewage or industrial wastes into any public waters of the state or waters forming the boundaries thereof which jeopardize the public health or the general welfare of the citizens of the state, unless works or means satisfactory to the director of health shall have been installed, within a time reasonable for the construction of the necessary works, for treating or otherwise disposing of such sewage or industrial waste. This section shall not apply to a sewer installed or to be installed for the use of a private residence or dwelling. Whoever violates any provision of this section shall upon conviction thereof be fined not more than five hundred dollars for each offense, and a separate offense shall be deemed to have been committed for each period of thirty days such violation shall continue after such conviction. Proceedings for the enforcement of the provisions of this section shall be instituted in the name of the state by the attorney general, whenever requested to do so by the director of health, in the county having jurisdiction or in the county of Franklin, as provided by law.. Nothing herein shall affect the provisions of section 1240-2 of the General Code."

Such legislation with the necessary teeth to make it workable has been promoted by health authorities and the medical profession for a number of years. It has been shown that 75 per cent of the urban population in Ohio uses surface waters as sources of supply for domestic purposes. At the same time, 35 per cent of the urban population discharges sewage into these same waters without any treatment whatsoever, and more than 50 per cent of industrial wastes are discharged into waters without treatment.

Officials of the Ohio Department of Health point out that this creates a burden upon the water purification works that cannot be handled satisfactorily.

The Ohio Department of Health previously had supervisory power over the dumping of wastes into public waters and had the responsibility of approving facilities for such dumping, however, the degree of pollution was never defined under the old regulations. Under the new law the Department is given authority to act under any dumping conditions "which jeopardize the public health or the general welfare of the citizens of the state."

MOBILE LABORATORY

In order to facilitate stream pollution control activities, the Division of Sanitary Engineering of the Ohio Department of Health is operating a mobile laboratory unit. The trailer is a 25-foot unit equipped with incubation, refrigeration, water tank under pressure, cabinet facilities and pertinent laboratory equipment for effective field service. Preparation has been made for chemical, bacteriological and biological examinations. The trailer is powered by a station wagon which also serves the purpose of collection of samples and transportation of field crews.

A survey of the Miami River and its tributaries is now under way. The crew began at the junction of the Miami River with the Ohio River and is working upstream. Further immediate plans call for extensive study of towns and industries along the Ohio River and its tributaries in keeping with an agreement of the Ohio River Compact. Other rivers and surface water bodies will be surveyed as time permits.

The Ohio River Valley Water Sanitation Compact was signed by representatives of Ohio and seven other states in June of last year. The purpose of the compact is to combine forces in the states of the Ohio Valley to influence local and national legislation to protect the Ohio River and its tributaries from the dumping of untreated sewage and wastes. The other states in the compact are Illinois, Indiana,



if she is one of your patients...

The farm housewife whose work is truly never done may find that the distressing symptoms of the climacteric make the smallest chore an arduous project. She depends on your help to resume normal efficiency in the performance of her daily tasks as well as to maintain a positive outlook during this trying period.

***"Premarin"** offers a solution. Many thousand physicians prescribe this naturally-occurring, oral estrogen because...*

1. *Prompt symptomatic improvement usually follows therapy.*
2. *Untoward side-effects are seldom noted.*
3. *The sense of well-being so frequently imparted tends to quickly restore the patient's confidence and normal efficiency.*
4. *This "Plus" (the sense of well-being enjoyed by the patient) is conducive to a highly satisfactory patient-doctor relationship.*
5. *Four potencies permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).*

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While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

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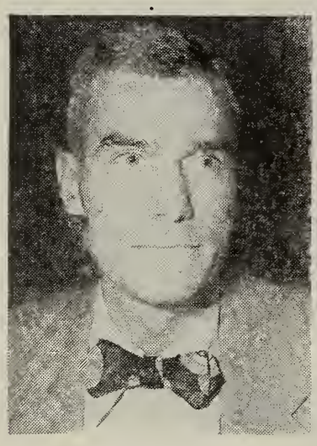
Kentucky, New York, Pennsylvania, Virginia and West Virginia.

A Federal enabling act, signed last year, promoted the antipollution program from the national level. A total of $2,200,000 has been appropriated by the present Congress to the Federal Security Agency to initiate the nationwide program of water pollution control and prevention which the act calls for but on which only preliminary planning has been possible up to now.

The appropriations break down as follows: $850,000 for the grants to states; $150,000 for allotments to state and interstate agencies for special studies which are of national or sectional importance; $1,200,000 for operation, research, administration and planning by the Public Health Service. Ohio's provisional allotment out of the $850,000 is $25,780.

Dr. Peterson Named Assistant State Health Director

Dr. Paul Q. Peterson is now assistant director of the Ohio Department of Health, a position to which he was appointed following the recent retirement of James E. Bauman, who held that responsibility for many years.



P. Q. PETERSON, M. D.

Dr. John A. Porterfield, director of the Department, announced with the appointment that Dr. Peterson would retain his former responsibilities as chief of the Bureau of Direct Services, one of the two bureaus of the Department. For the present at least, he also will continue as acting chief of the Bureau of Local Services.

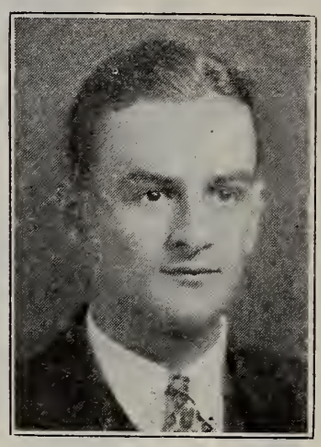
Dr. Peterson has been with the State Department nearly two years now and has shown a promising aptitude for the work. A graduate of the University of Illinois College of Medicine, he also received a degree as Master of Public Health from the University of Michigan School of Public Health. His background of experience includes private practice in addition to considerable public health work.

Dr. Porterfield announced also the appointment of Mr. Earl O. Wright, former U. S. Public Health Service worker, as chief of the Division of Administration, another position formerly held by Mr. Bauman.

Mr. William H. Veigel, chief of the Division of Vital Statistics, has been appointed secretary of the Public Health Council, another position formerly held by Mr. Bauman.

Dr. Tapper Is Named to State Medical Board

Dr. Ralph W. Tapper of Dayton is the new member of the State Medical Board to succeed Dr. Dwight J. King of Findlay whose term of office expired this year. His nomination by Governor Frank J. Lausche was confirmed by the Senate late in July. His term of office will expire on March 18, 1956.



R. W. TAPPER, M. D.

Dr. King, whose seven-year term expired in March, in accordance with procedure, continued in office until his successor was appointed and qualified.

A native Daytonian, Dr. Tapper has been a life resident of that city. After three years of premedical training at Ohio State University, he went to the University of Cincinnati where he received the degree of B. S. and was presented his degree as Doctor of Medicine from the same university's College of Medicine in 1936.

After completing his internship and residency training at Miami Valley Hospital, he became associated for a time in practice with Dr. A. B. Brower and Dr. Thomas P. Sharkey.

During World War II, Dr. Tapper served three years with the Army Air Corps, including service in Japan as chief medical officer in the 376th Station Hospital.

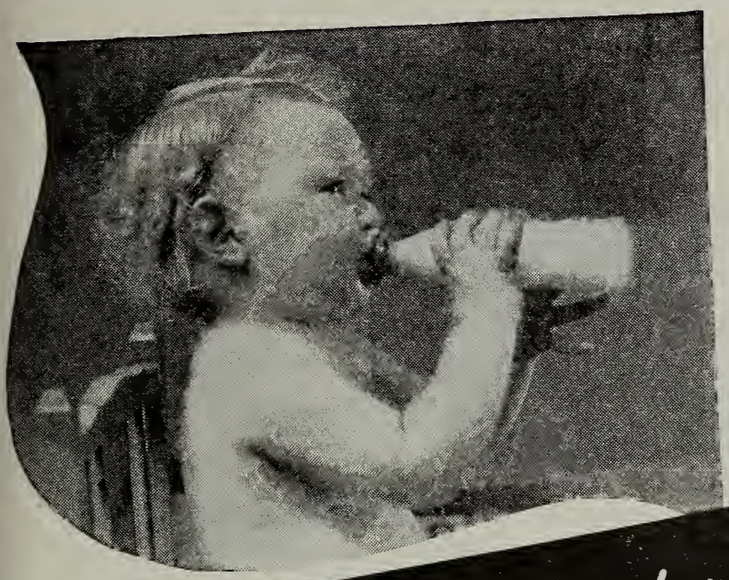
Upon his return to civilian life, he resumed his practice in Dayton, which he is now limiting to internal medicine. His professional work includes membership on the active staff of Miami Valley Hospital.

Dr. Tapper is a member of the Montgomery County Medical Society, the Ohio State Medical Association and the American Medical Association. He and Mrs. Tapper have two children, Judy, 11, and Debbie, 2½.

Other members of the State Medical Board are: Dr. C. W. Waggoner, Toledo, president; Dr. J. N. McCann, Youngstown; Dr. Thomas H. George, Cleveland; J. O. Watson, D. O., Columbus; Dr. Ralph B. Taylor, Columbus; Dr. W. M. Hoyt, Hillsboro; Dr. P. H. Charlton, Columbus, treasurer; and Dr. H. M. Platter, Columbus, secretary.

Dr. Roy W. Scott, Cleveland, and Dr. M. A. Blankenhorn, Cincinnati, were reappointed for three year terms as members of the American Board of Internal Medicine which met in Philadelphia on June 1.

From birth to the end of the bottle-feeding period



BAKER'S MODIFIED MILK

—well tolerated by both premature and full-term infants



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Baker's Modified Milk is supplied as powder or liquid. Both forms may be fed interchangeably to meet individual requirements.

YOU will be pleased by the highly satisfactory growth, firm muscle tone and tissue turgor when you prescribe Baker's Modified Milk, because Baker's is a highly nutritious food complete (except for Vitamin C) for infants from birth throughout the bottle-feeding period.

Closely conforming to human milk, Baker's is well tolerated by both premature and full-term infants. No change in formula is required as the baby grows older—just increase the quantity of feeding.

These are qualities making Baker's Modified Milk a fast-growing favorite among doctors. Obstetrical department personnel and mothers are especially pleased when Baker's is prescribed, because Baker's requires no complicated feeding directions. For normal feeding strength, merely dilute liquid Baker's with equal parts of boiled water.

Just leave instructions with the obstetrical supervisor at the hospital. She will be glad to put your bottle-fed babies on Baker's.

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Do You Know? . . .

Wayne E. Stichter, Toledo, General Counsel for Ohio Medical Indemnity, Inc., is the new President-Elect of the International Association of Insurance Counsel.

* * *

The new state director of mental hygiene for California is Dr. Frank F. Tallman, Columbus, professor of clinical medicine and psychiatry at Ohio State University College of Medicine and formerly commissioner of mental hygiene.

* * *

Dr. J. J. Carter, Columbus, was named assistant secretary of the National Medical Association at its recent annual convention in Detroit.

* * *

A recent survey of 653 Catholic hospitals in the United States disclosed that the average percentage of Blue Cross patients in Catholic hospitals in Ohio was 42 per cent.

* * *

Two states—Minnesota and Wisconsin—recently passed animal procurement laws, to permit universities to requisition dog-holding agencies for animals needed in medical, dental, veterinary and biological investigations. Similar legislation failed in Pennsylvania, Illinois and Oklahoma.

* * *

Guest speakers at the annual session of the American Congress of Physical Medicine to be held at Cincinnati, September 6-10, include Dr. Bruce C. Martin, Columbus, whose subject is "Use of Skin Grafts in Rehabilitation," and Dr. Fay A. LeFevre, Cleveland, who will talk on "Physical Medicine and Peripheral Vascular Disease."

* * *

During the Civil War the Union Army with less than a million men had 75,368 cases of typhoid, compared with only 42 cases in World War II, when more than ten million American men and women were in the service.

* * *

Dr. Martha M. Eliot, associate chief of the U. S. Children's Bureau, has resigned to become assistant director general of the United Nations World Health Organization.

* * *

Dr. Cyril H. C. Francis, who was the first medical director of the Columbus Branch office of the Veterans Administration and was later transferred to Denver, has been named one of the six area medical directors to supervise hospitals and other V. A. medical matters throughout the country. Since the elimination of the V. A.'s 13 branch offices, the supervisory functions of the former branch office medical staffs now are centered in the office of the Chief Medical Director in Washington.

* * *

Dr. Louis Mark, Columbus, was chosen president-elect of the American College of Chest Physicians at its meeting in Atlantic City, N. J.

* * *

The name of the Franklin County Tuberculosis Hospital has been changed to the Benjamin Franklin Hospital.

* * *

To complete its files, the Oberlin Library needs certain numbers of the following publications for 1946, 1947 and 1948: *American Journal of Surgery, American Journal of the Medical Sciences, Journal of the American Medical Association* and *American Journal of Nursing.*

* * *

Students in a course in Administrative Interrelationships in School Health Education at the Ohio State University Summer School were addressed by Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, August 8. He spoke on "Relationship of the American Medical Association, Ohio State Medical Association and the County Medical Societies of Ohio to School Health Education Programs."

* * *

The Ohio Society for Crippled Children, Inc., reported that sales for Easter seals in the state amounted to $369,027. Of this amount, 08.3 per cent goes to the National Society for Crippled Children and Adults while the remainder will be used in Ohio.

* * *

According to the *Cleveland Press,* Greater Cleveland has established an all-time record among cities in the number of persons examined in the free chest X-ray survey. By mid-June, 504,000 persons had been examined and this number was expected to reach 650,000 by the end of the survey in August. The previous record was established last year in Washington, D. C., with 503,444.

* * *

The next scheduled examination (Part I) of the American Board of Obstetrics and Gynecology, written examination and review of case histories, for all candidates will be held in various cities of the United States and Canada on Feb. 3, 1950. Applications may be made until November 5 to the Board at 1015 Highland Bldg., Pittsburgh 6, Pa.

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First 50-Year Pin Presented . . .

Dr. Murbach of Archbold Is Honored With First Half-Century Emblem; Many Other Members of Association Will Receive Pins in Near Future

A HOMECOMING celebration at which Dr. Edwin A. Murbach of Archbold was honored for his long and outstanding contribution to the community was made the occasion for presentation of the first of the Ohio State Medical Association's 50-year medical service pins.

The gold pins were authorized by the House of Delegates at the 1948 Annual Meeting and will be presented to members of the Association (or former members) who have been Doctors of Medicine over a period of a half century. The Headquarters Office has been compiling a list of physicians eligible to receive the pins. This list is now approaching completion and plans are now being made to have other pins presented during the coming fall and winter seasons.



Photo by J. L. Sellers, Archbold

Dr. A. A. Brindley (left), Past-President of the Association, is shown presenting the certificate to Dr. E. A. Murbach after pinning on his lapel the first emblem for 50 years of medical service.

Thousands of persons witnessed as Dr. A. A. Brindley of Toledo, immediate Past-President of the Association, presented the pin and certificate to Dr. Murbach. The celebration was sponsored jointly by the local American Legion Post and the Boosters Club. Featured event of the two-day celebration was Appreciation Day, honoring Dr. Murbach for his half-century of medical and civic service.

A registration book containing signatures of more than 1,200 former patients, friends and citizens was presented to Dr. Murbach by Harold F. Stotzer, Fulton County's representative in the Ohio General Assembly. An engraved gold wrist watch also was presented to the Doctor.

Dr. Murbach was acclaimed also for his work as a member of the Archbold Board of Education for nearly 50 years, for his work as a church leader and for his efforts in helping to secure Fulton County's first hospital at Wauseon.

Dr. Murbach graduated from the University of Michigan Medical School, Ann Arbor, in 1894. Except for one year of intern training at Ann Arbor, he practiced continuously in Archbold from that time until his retirement in 1946. At the conclusion of 53 years of medical practice, he was named to the Emeritus Club of the University of Michigan.

Northwestern Association Schedules Session in Toledo, Oct. 4

The 105th Session of the Northwestern Ohio Medical Association is scheduled to be held on Tuesday, October 4, at the Commodore Perry Hotel, Toledo.

Included on the program are the following nationally known physicians:

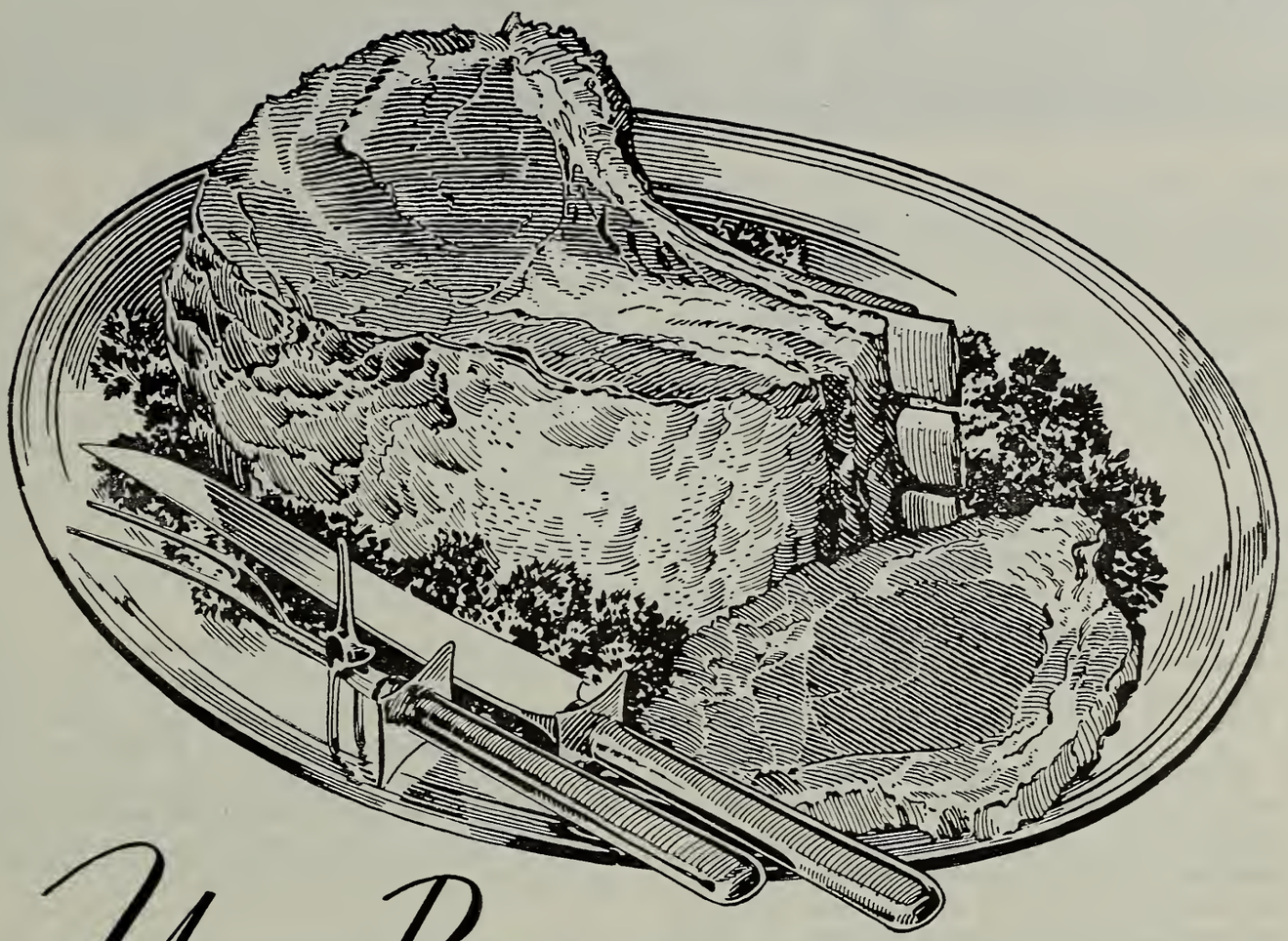
Dr. John S. Lundy, Rochester, Minn., professor of anesthesiology at the Mayo Foundation and graduate school of the University of Minnesota.

Dr. Paul K. French, Burlington, Vt., professor of clinical medicine, University of Vermont, and a member of the Board of Governors of the American College of Physicians who will talk on "Antibiotic Therapy."

Dr. Gerald H. Pratt, New York City, chief of vascular surgical service and chief of general surgical clinic at New York Postgraduate Hospital, whose topic will be "Peripheral Vascular diseases."

Dr. William M. Tuttle, Detroit, Mich., senior associate with Dr. E. J. O'Brien in thoracic surgery.

Registration begins 9:30 a. m. At a noon luncheon, Wilbur W. White, Ph. D., president of the University of Toledo, will speak.



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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

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"The Senator must know . . . that socialized medicine in Britain is costing almost as much for their 40,000,000 people as (private medicine) cost our 150,000,000 in 1946. Compulsory health insurance can only lead to inferior medical care at a much greater cost."—*Dr. David W. Heusinkveld, Cincinnati, in answer to an article by Senator James E. Murray.*

* * *

"Some of the stories of British care under the new plan turn one's blood cold . . . Just because we need more medical care isn't any reason to put so much power over life and death into the hands of the government."—*Congresswoman Frances P. Bolton, as quoted in the Columbus Dispatch.*

* * *

"Many British hospitals, under the National Health Service, are so jammed that non-emergency cases must wait almost indefinitely for bed accommodations. Average waiting time for a tonsillectomy at one London hospital is sixteen months."—*William Alan Richardson, editor of Medical Economics.*

* * *

"A good deal of the Labor Party's legislation in the last four years amounted to action as irreversible as going over Niagara Falls in a barrel. The Health Plan, no matter how unwisely framed, is now considered politically untouchable. Before we get involved in any similar efforts, it may pay us to kibitz for a while."—*The Saturday Evening Post.*

* * *

"Actually, most Americans *can* pay for medical care. Practically anyone who can meet his other bills can meet his medical bills as well, if he chooses—either directly or through insurance.

"In 1947 the American people spent $10 billion for liquor, $4 billion for tobacco, and over $2 billion for cosmetic items—to mention only a few of the non-essentials. In the same year they spent $1.7 billion for physicians' services."—*You and Socialized Medicine," by Chamber of Commerce of the United States.*

* * *

"So far as the British Health Scheme is concerned, it is a major expression of the welfare state idea, and as a health scheme, it is very similar to the plan President Truman has proposed for this nation. It is too early to tell what it has accomplished for the health of the British people, but there are definite signs that it has done something to their faith in themselves. If this nation of ours should ever adopt the same kind of a scheme, we must be prepared to accept the same increases in taxes and government controls. But of much greater significance is the depressing effect upon the spirit of the people."—*John W. McPherrin, Editor, The American Druggist,* on his return from England.

* * *

"The proposed plan for governmental medicine, they say, will not change anything except the method of payment for services. Why then should it require 163 pages, as in the proposed law, and a confused organization of hundreds of councils, boards, committees and similar agencies just to collect and distribute money?" —*Insurance Economics Surveys.*

* * *

"I realize that it is useless to emphasize this point to those who love the discursive side of mass medicine, and who too often visualize themselves in an executive berth. However, it is my hope that, before this nation plunges into subsidizing Mrs. Jones' miseries and compelling Mr. Jones to take his broken leg to Doctor #711, we will have a really critical look at our military medicine and, particularly, at socialized medicine in England and the Scandinavian countries."—*Robert A. Hornby, vice-president, Pacific Lighting Corporation, San Francisco.*

* * *

"Britons were surprised—and nettled—recently when he (Sir Stafford Cripps) went to Switzerland for his health, instead of using England's health plan."—*E. T. Leech, Editor, The Pittsburgh Press, in Scripps-Howard series entitled UTOPIA ON THE ROCKS—BRITISH SOCIALISM IN ACTION.*

* * *

"Look over all the world where you will and see those governments where the features of compulsory benevolence have been established, and you will find the initiative taken from the hearts of the people."—*Samuel Gompers in a 1916 statement as president of the A. F. of L.*

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State Medical Board Authorizes 213 Graduates of Medical Schools To Practice in This State Following June Examinations in Columbus

RESULTS of the examinations conducted by the State Medical Board of Ohio on June 15-18 were considered by the Board at its meeting on August 2.

A total of 213 graduates of schools of medicine will receive certificates to practice medicine and surgery.

Highest grade in the medical examinations was made by John M. Verosky, Swissvale, Penna., with 91.5 per cent. Second highest was Mildred L. Geiger, Columbus, with 91.3 per cent; and third place was taken by James R. West, Cuyahoga Falls, with 90.9 per cent. All three are graduates of Ohio State University College of Medicine.

Nine graduates of osteopathic schools will receive certificates to practice osteopathic medicine and surgery and one applicant who appeared for additional examinations will receive a certificate to practice osteopathic medicine and surgery.

In addition, in the limited branches, certificates will be awarded to seven mechanotherapists, three chiropractors, one chiropodist, six cosmetic therapists and 22 masseurs.

Graduates of medical schools who will receive certificates to practice medicine and surgery are the following:

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE: John Grant Bolen, Columbus; J. Thornton Boswell, Columbus; Edward John Broaddus, Irvine, Ky.; Warren Joseph Brown, Pottstown, Penna.; Alethea Jones Buccalo, Columbus; Donald Kimmel Cameron, Toledo; Gwendolyn Campbell Trudeau, Columbus.

Robert Louis Campbell, Columbus; Ray Carroll, Columbus; Robert Frank Cooper, Zanesville; John Patrick Crawford, Columbus; Jo Ann Dawson, Columbus; William Holt Donovan, Jr., Columbus; Glenn Coe Dowell, Jr., Columbus.

Matthew William Elson, Columbus; Richard Johnston Fogle, Toledo; James G. Forgerson, Oakland, Calif.; Mildred Louise Geiger, Columbus; Floyd Earl Herold, Parma; Hope Hyams, Cincinnati; Ernagene Fortescue Ingram, Dayton; Howard Neil Karp, Toledo; Roland Louis Kennedy, Toledo; Joe Stewart Kirkpatrick, Lockbourne; Reynold Edward Klages, Jr., Canton; Herbert W. Lohmuller, Philadelphia, Penna.; James Richard Monroe, Columbus; Wesley Jules Rynolet, Philadelphia, Penna.; Douglas Boyd Price, Tacoma, Wash.

Edythe Clay Pritchard, Attica; Kirkwood Arthur Pritchard, East Cleveland; Myer David Protetch, Youngstown; Robert Lee Prouty, Cleveland Heights; Barbara Anne Reed, Columbus; Carroll H. Robie, Jr., Lexington, Ky.; Jerold Mark Rosenblum, Youngstown.

Alvin Burton Salisbury, Jr., Columbus; David Joseph Spangler, Columbus; Herbert Kenneth Speers, Philadelphia, Penna.; John E. Stephens, Columbus; Constance Marcile Straw, Los Angeles, Calif.; Jonathan Skiles Thatcher, Wooster.

John M. Verosky, Swissvale, Penna.; Donald William Walters, Columbus; Creed F. Ward, Cleveland; James R. West, Cuyahoga Falls; Arnold Windt, Bronx, New York; Andrew J. Zito, Portland, Ore.

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE: James Whitman Agna, Troy; Betty Ann Alf, Newport, Ky.; Richard Allen Allnutt, Covington, Ky.; David Winthrop Anderson, Dayton; Jeanne S. Anderson, Dayton; Neal Irwin Aronson, Brooklyn, N. Y.; Taylor Asbury, Cincinnati.

Robert J. Bamberger, Latonia, Ky.; Lawrence J. Barrows, Cincinnati; William Daniel Benham, Cincinnati; Howard G. Berninger, Cincinnati; Irwin Leonard Bernstein, Cincinnati; Carl Heggen Birkelo, Detroit, Mich.

Robert Bloomer, St. Thomas, Ontario, Can.; Richard Edward Boiman, Cincinnati; Theodore Edward Buka, Cincinnati; Besse Lee Caine, Wyoming; Daniel H. Casriel, Bradley Beach, N. J.; Paul Robert Click, Cincinnati; Claran Clifton Cobb, Jr., Avard, Okla.

James William Crawley, Cincinnati; Arthur Vernon Dudley, Jr., Santa Monica, Calif.; Kenneth William Ehrhart, Glenville, Pa.; Kenneth Joseph Engel, Cincinnati; Laurence Leon Essig, Cincinnati; Kenneth A. J. Frederick, Cincinnati; Don Hughes Frickman, Fort Thomas, Ky.

William Clay Fritz, Covington, Ky.; William Finley Fry, Jr., Cincinnati; Clifford Kent Gleaves, Cincinnati; Foy Wallace Green, Jr., Cincinnati; Thomas Henry Greine, Cincinnati.

Joseph William Hance, Cincinnati; Rae Elizabeth Hartman, Cincinnati; Louis Fillmore Heyman, Youngstown; John Francis Hughes, Columbus; Maxine Ruth Keiter, New Burlington; George Henry Koepke, Toledo.

Arthur Julius Kuhn, Cincinnati; Robert George LaCamera, Warren; Sammy Spencer Leber, Danville, Ky.; Carl Arthur Liebig, Cincinnati; Raymond Joseph Lippert, Cincinnati; Melvin A. Lucas, Cincinnati; Charles E. Maurmeier, Cincinnati.

Dale W. McDowell, Pittsburgh, Pa.; Robert Nathaniel Montgomery, Cincinnati; Dora Belle Muhlberger, Newtown; Harry B. Neustein, Pitts-

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WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE: Robert Leonard Theodore Adamich, Cleveland; Macelyn Valstin Anders, Marietta; Elmer James Ballintine, Cleveland; Irving Berke, Cleveland; Matthew Rocco Biscotti, Cleveland.

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GRADUATES OF OTHER SCHOOLS: Columbia University—Otto F. Apel, Jr., Portsmouth.

Cornell University—Donald K. Stockdale, Cincinnati.

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Marquette University—Paul A. Dobson, Youngstown; Ernest Segnalla, Jr., Hamilton.

McGill University—Thomas I. Crawford, Cleveland.

Northwestern University—Joseph A. Buchman, Cincinnati; Raymond N. Catoline, Youngstown.

State University of Iowa—John F. McGreevey, Akron.

Syracuse University—James W. Hepplewhite, III, East Liverpool.

University of Berlin—Ernest Schmerl, Toledo.

University of Bern—Gerhard Hoffman, Cleveland.

University of Budapest—Barbara O. Remetey, Cleveland.

University of Glasgow—Herbert M. Marks, Philadelphia, Penna.

University of Illinois—William G. Rice, Springfield.

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Feinberg, S. M.: Postgrad. Med. 3: 92 (1948).

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Levin, L.; Kelly, J. F., and Schwartz, E.: New York State J. Med. 48: 1474 (1948).

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Brown, G. T.: M. Ann. District of Columbia 16:675 (1947).

Pollen desensitization "still remains the treatment of choice in hay fever."

Rosen, F. L.: J. M. Soc. New Jersey 45: 390 (1948).

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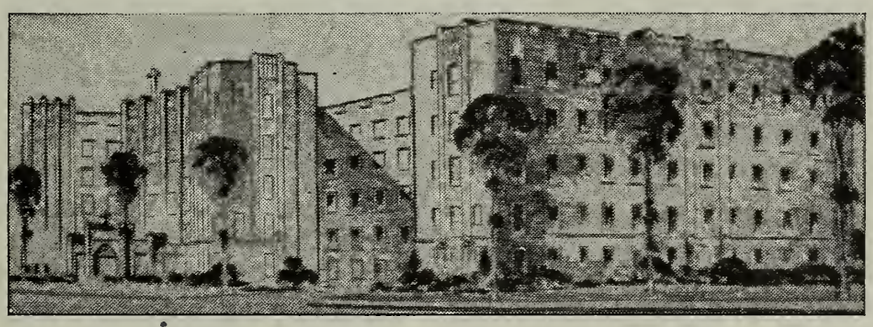
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Anesthesiologists To Meet in Akron September 23-24

The Annual Meeting of the Ohio Society of Anesthesiologists will be held in the Hotel Mayflower, Akron, Friday and Saturday, September 23 and 24. The program is scheduled as follows:

FRIDAY, SEPT. 23

9:00- 9:10 a. m. Announcements by Dr. A. William Friend, Akron, and message by Dr. K. C. McCarthy, Toledo, president of the Society.

9:10- 9:30 "Preoperative Preparation of Patients," Dr. C. F. Schmitt, Canton.

9:30-10:10 "Cyclopropane Anesthesia for Infants and Adolescents," Dr. G. F. Collins, Columbus.

10:00-10:30 "Selection of Anesthesia for Children," Dr. F. A. Oldenburg, Akron.

10:45-11:30 "Clinical Applications of Supplemental and Complemental Respiration," Dr. H. C. Slocum, University of Texas, Galveston.

11:30-12:00 "Blood Pressure Control With Intravenous Vasopressor Drugs," Dr. R. L. Patterson, Pittsburgh, Pa.

1:30- 2:00 p. m. "Anesthesia for Laryngectomy," Dr. R. M. Crane, Cleveland.

2:00- 3:00 Panel: "Fire and Explosion Hazards," moderator, Dr. R. L. Patterson; "Precautions When Using Flammable Agents in the Operating Room," Dr. Sidney Katz, Cleveland; "Grounding Devices in the Control of Static," Dr. Nicholas Depiero, Cleveland; "Special Precautions When Using Various Electric Equipment in the Operating Room," Dr. L. E. Larrick, Cincinnati.

3:15- 4:00 "Establishment and Function of Pain Clinics," Dr. Donald Stubbs, George Washington University, Washington, D. C.

4:15-4:45 "Anesthesia for Splenectomy," Dr. John Garvin, Columbus.

4:45- 5:00 Business meeting.

A cocktail hour will begin at 6 p. m. followed by a banquet at 7 p. m. Dr. R. J. Whitacre, Cleveland, president-elect of the American Society of Anesthesiologists will speak on the subject, "Development of Policies in the Practice of Anesthesiology." Entertainment will follow.

SATURDAY, SEPT. 24

9:00- 9:30 a. m. "Pentothal in Conjunction With Other Agents for Endoscopy," Dr. D. W. Metcalf, Youngstown.

9:30-10:15 "Cardiac Arrythmias," Dr. H. C. Slocum, Galveston, Texas.

10:30-11:30 Panel: "Anesthesia for Poor Risk Patients," moderator, Dr. J. K. Potter, Cleveland; "Anesthesia Management of Traumatic and Emergency Surgery," Dr. E. P. Knisley, Worthington; "Anesthesia Management of Certain Cardiac-Respiratory Problems," Dr. J. P. Curran, Dayton; "Anesthesia Management of Patients With Various Metabolic Diseases," Dr. J. J. Thomas, Alliance.

11:30-12:00 "Surgical Shock—Clinical Diagnosis and Management," Dr. Donald Stubbs, Washington, D. C.

Industrial Medicine Section Arranged At Ohio Safety Conference

One of the feature sessions of the Ohio State Safety Conference in Cleveland, September 20-22, will be the Section on Industrial Medicine arranged by the Ohio State Medical Association's Committee on Industrial Health and Workmen's Compensation.

Officials of the Safety Conference invited the Association to participate by arranging a program. Under the chairmanship of Dr. H. P. Worstell of Columbus the Committee on Industrial Health and Workmen's Compensation has arranged an outstanding panel of speakers.

The section will meet at 2:15 p. m. on Wednesday, September 21, in the Embassy Room, Hotel Carter, Cleveland. All physicians interested in industrial medicine or allied practices will find this section of particular interest. Others interested in the section will include industrial relations personnel and nurses engaged in industrial nursing.

The Committee was fortunate in arranging a panel of four speakers, all nationally known in their respective fields. The program will consist of the following topics and speakers:

"The Industrial Physician: A Job Analysis," by Dr. William J. Fulton, medical director, General Motors Corporation, Detroit, Mich.

"Tailoring Industrial Medicine To Fit the Plant," by Dr. Carl T. Olson, division medical director, Loss Prevention Department, Liberty Mutual Insurance Company, Chicago, Ill.

"A Biologist Looks at Accident Prevention," by Dr. Ross A. McFarland, associate professor of industrial hygiene, Harvard School of Public Health, and medical coordinator, Pan-American World Airways System, Boston, Mass.

"Industrial Health—Who Is On The Team?" by Dr. Carl M. Peterson, secretary of the Council of Industrial Health, American Medical Association, Chicago.

Dr. James N. Wychgel, Cleveland, member of the Committee which arranged the program, will be moderator of the section. Discussions will follow the panel.

1950 Obstetricians' Meeting

The 18th Annual Meeting of the Central Association of Obstetricians and Gynecologists will be held Thursday through Saturday, September 21-23, 1950, at the Hotel Schroeder, Milwaukee, Wis.

In Memoriam . . .

George Edward Black, M. D., Akron; Eclectic Medical College, Cincinnati, 1909; aged 63; died June 28; member of the Ohio State Medical Association and a Fellow of the American Medical Association.

Thomas Aloysius Burke, M. D., Cleveland; Western Reserve University School of Medicine, 1888; aged 85; died July 18 in Duluth, Minn., while on a vacation trip; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American Laryngological Association. Dr. Burke practiced medicine in Cleveland for more than 61 years and in spite of his age was active to the last. In addition to his professional practice, he was a sports enthusiast, took an active part in the Democratic Party and was director of several business firms. He served two terms as county coroner and is credited with many safety reforms while in office. He has written extensively on medical subjects and has taken active part in national medical organizations. He was a member of the Catholic Church and the Knights of Columbus. Surviving are two daughters and a son, Thomas A. Burke, Jr., mayor of Cleveland.

Carroll Durham Conard, M. D., Mount Vernon; Cleveland-Pulte Medical School, 1914; aged 58; died July 26; member of the Ohio State Medical Association and the American Medical Association; chairman of the Legislative Committee of the Knox County Medical Society, 1942-45. Dr. Conard practiced his profession in Mount Vernon for approximately 30 years. A veteran of World War I, he was a member of the Veterans of Foreign Wars and of the Elks Lodge. Surviving are his widow, a son and a daughter.

Albert D. DeHaven, M. D., Xenia; Bennett College of Eclectic Medicine and Surgery, Chicago, 1888; aged 83; died July 24; member of the Ohio State Medical Association and the American Medical Association. Dr. DeHaven practiced medicine in Xenia for more than 50 years, during which time he served on the former city council and as a city commissioner under the new form of government. For a brief period also he was mayor of the city. For a number of years he served as examining physician for the Metropolitan Life Insurance Co., and was interested in several local business enterprises. He was a member of the Reformed Church, the

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Masonic Lodge and the Elks Lodge. Surviving are his widow, a son and a brother.

Harold H. Foreman, M. D., Akron; Howard University College of Medicine, Washington, D. C., 1933; aged 41; died June 21; member of the Ohio State Medical Association and the American Medical Association.

Eugene Hemmeger, M. D., Adelphi (Ross County); Starling Medical College, Columbus, 1895; aged 74; died July 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Hemmeger practiced his profession in Ross County for more than 54 years. A reunion for patients of his had been scheduled for September 10 which would have been his 75th birthday. He was president of the Adelphi Bank, was a member of the Methodist Church, and several Masonic orders. Surviving are his widow, three daughters, a stepdaughter, a brother and a sister.

Norman William Ingalls, M. D., Cleveland; Western Reserve University School of Medicine, 1905; aged 69; died July 27; former member of the Ohio State Medical Association and the American Medical Association through 1938; member of the American Association of Anatomists. Dr. Ingalls retired in 1937 after 32 years on the faculty of Western Reserve University School of Medicine. He held memberships in the National Medical Advisory Board, the National Board of Medical Examiners, the Pasteur Club, the Cleveland Medical Library and the National Association for the Advancement of Science. Surviving are his widow, a son, a daughter and a sister.

Raymond Maurice Malone, M. D., Galion; Ohio State University College of Medicine, 1925; aged 51; died July 15; member of the Ohio State Medical Association and the American Medical Association; chairman of the Legislative Committee of the Crawford County Medical Society 1929-30; secretary-treasurer of the society in 1930 and 1943 and its vice-president in 1935 and 1942. Dr. Malone practiced in Galion and vicinity for approximately 22 years. Surviving are his widow, two sons and a daughter.

Edward L. McElfresh, M. D., Point Pleasant, W. Va.; Starling Medical College, Columbus, 1893; aged 79; died July 23. Dr. McElfresh practiced medicine in Mason County for 56 years. He was a veteran of World War I; was a member of the Methodist Church and the Masonic Lodge. Surviving are his widow, a son and a brother.

Lucius Warner Prichard, M. D., Ravenna; University of Wooster, Medical Department, Cleveland, 1892; aged 84; died July 11; member of the Ohio State Medical Association and the American Medical Association through 1948;

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president of the Portage County Medical Society in 1927. Dr. Prichard moved his practice to Ravenna in 1896 and even in recent years continued his profession on a limited scale. He was a veteran of the Spanish-American War and World War I, was a 50-year member of the Masonic Lodge, and was associated with the Rotary Club, the American Legion, the Odd Fellows Lodge and the Congregational Church. Surviving are his widow, three daughters and two sons.

Gilbert J. Sheekley, M. D., Cleveland; St. Louis University School of Medicine, 1947; aged 26; died July 23. Dr. Sheekley was a resident physician at People's Hospital. Surviving are his widow, a daughter, his father and two brothers.

Lewis Frederic Smead, M. D., Toledo; Johns Hopkins Medical School, 1905; aged 71; died July 28; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Surgery; member of the American College of Surgeons and the American Association of Obstetricians, Gynecologists and Abdominal Surgeons; president of the Academy of Medicine of Toledo and Lucas County in 1924. Dr. Smead moved to Toledo in 1908. He was a member of the Presbyterian Church, the Rotary Club and the Toledo Club. Surviving are his widow, two sons, a daughter and a sister.

Donald Alfred Waag, M. D., Dayton; Western Reserve University School of Medicine, 1943; aged 37; died July 29; member of the Ohio State Medical Association and the American Medical Association through 1948. Dr. Waag gave up his practice about two years ago because of ill health. He is a veteran of World War II. Surviving are his widow, a daughter, a son, his parents, a sister and two brothers.

Emmett Burns Whigam, M. D., Akron; Cleveland Medical College, Homeopathic, 1895; aged 76; died July 6; former member of the Ohio State Medical Association and the American Medical Association through 1936. Dr. Whigam practiced in Akron for approximately 37 years, 20 years of which he was police and fire surgeon. He held membership in the Methodist Church, several Masonic orders, the Burns Club and the Summit County Historical Society. Surviving are his widow, two daughters and two sisters.

Hospital Executives To Meet

The 28th annual Hospital Standardization Conference will be held at the Stevens Hotel in Chicago, October 17-21, as a part of the 35th Clinical Congress of the American College of Surgeons. Several hundred executives from the United States, Canada and a few other countries are expected to attend.

Proposed Department of Welfare Killed by Senate Bill

President Truman's attempt to create a new department of welfare by executive order was defeated in the United States Senate August 16. A resolution disapproving the proposal sponsored by Sen. Robert A. Taft, carried by a vote of 60 to 32. Sen. John W. Bricker voted for the Taft resolution, which was supported by 37 Republicans and 23 Democrats. Only four Republicans and 28 Democrats favored the President's plan for consolidating the government's welfare, education and public health activities into one department, headed by a Cabinet officer.

The American Medical Association, Ohio State Medical Association and other medical societies vigorously opposed the reorganization plan. It was pointed out to members of the Congress that consolidation of the welfare, educational and health activities of the Federal Government in a department of welfare would likely result in subordinating medical-health activities. Representatives of the medical profession favored merging Federal health programs in a "United Medical Administration," as recommended by the Hoover Commission, under the direction of a physician-administrator with Cabinet status.

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Pathology and the Coroner . . .

Ohio Physician Reviews Role of Coroners and Offers Suggestions for Making Pathological Services Available to Those in Outlying Areas

THE principal duties of the county coroner are to conduct adequate investigations into those deaths which, according to the laws of Ohio, come under his jurisdiction, and to maintain records of those investigations.

(General Code of Ohio, Section 2855-5 states: "When any person shall die as a result of criminal or other violent means, or by casualty, or by suicide, or suddenly when in apparent health, or in any suspicious or unusual manner, the physician called in attendance shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and circumstances of such death and any other information which may be required pursuant to the death.")

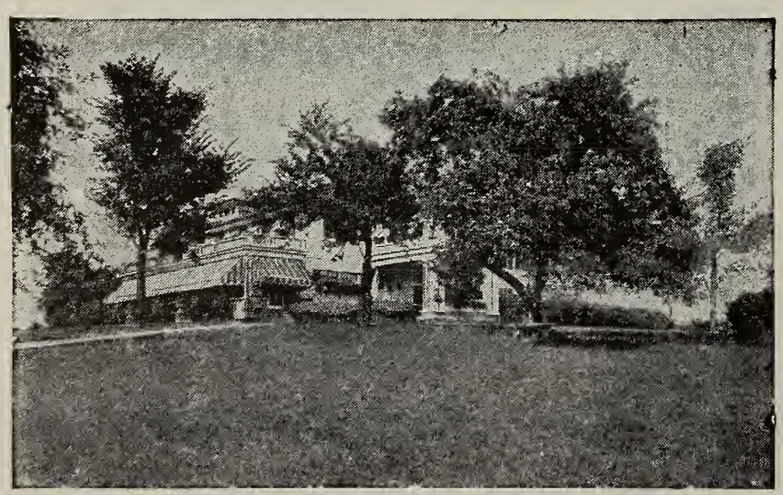
The coroner must determine the mode and manner of the death. As a part of an investigation, he is empowered to perform, or have performed, an autopsy. Whenever criminal responsibility for a death is known or suspected, an autopsy is required. In some cases, an absence of positive information is sufficient to warrant an autopsy; this is true when the circumstances in which the death occurred are so obscure that criminal responsibility cannot be excluded.

In those cases in which an autopsy is deemed necessary by the coroner, the autopsy should be done by a competent pathologist with the utmost thoroughness and care. On the result of the autopsy may depend the freedom or even the life of one or more individuals who may be suspected of responsibility for the death.

The quality of an official investigation into a death, and the quality of an autopsy made as a part of that investigation, should not be less in rural areas than the quality of similar investigations and autopsies made in urban centers. Until all deaths that come under the jurisdiction of the coroner are competently investigated and the autopsies which are required are properly made by qualified pathologists, the public should not feel complacent about the following four important matters: (1) that murders will be recognized as such, and will not be mistaken for deaths from natural causes, or accidents or suicides; (2) that facts and objects of evidence will be properly preserved so as to aid in the apprehension and prosecution of persons responsible for homicides; (3) that persons innocent of crime will not be suspected or accused of homicide; (4) that unsuspected hazards to the public health will be recognized at the earliest possible time, so as to be brought under adequate control.

There are probably few regions in Ohio where there was not at least one instance during the last ten years of an unexpected death which occurred under unusual circumstances and was

The accompanying article was written by Frank R. Dutra, M. D., Office of the Coroner of Hamilton County and the Kettering Laboratory of Applied Physiology, University of Cincinnati College of Medicine, and is based on an address given by him before the Ohio State Coroners Association at its annual seminar meeting in Toledo.



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defined officially as suicide, accident, or death from natural causes. Proper investigation would certainly have revealed that some of these deaths were due to homicide, while others would have been proved beyond all doubt not to be homicide. A competent investigation of the homicidal deaths would have revealed facts and objects that would have led to the solution of most of the murders, while the pall of suspicion would have been removed unequivocally from one or more persons by appropriate investigation of those which came about otherwise.

One of the most apparent deficiencies in the investigation of many of the obscure and suspicious deaths which come under the jurisdiction of the coroner is the lack of an autopsy made by a competent pathologist.

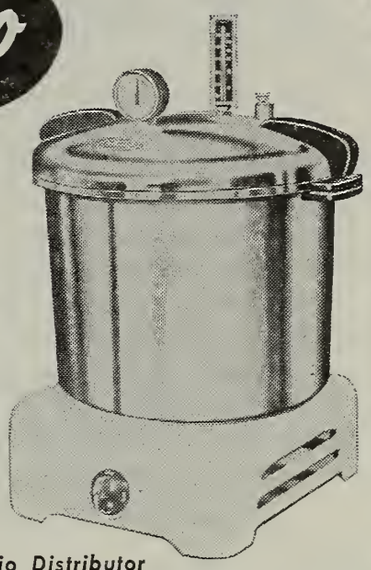
DISTINCTION IN TYPE

There are important differences between the usual hospital autopsy and an autopsy made as a part of a coroner's investigation. Hospital autopsies are important for the continued progress of medical education and development. The objectives of the hospital autopsy are to determine the cause of death, to elucidate any complications which may have contributed to a fatal outcome in the particular case, and to determine the effects that treatment might have had on the condition from which the patient was suffering. Thus, it may be said that the hospital autopsy is made for the purpose of obtaining information that will aid in the better diagnosis of other cases of the same or similiar diseases, and to obtain facts which may add to the general corpus of medical knowledge.

The pathologist who makes an autopsy as a part of an official investigation into a death should also attempt to gain information of the type described above. In addition, he recognizes that there is an immediate need for information from the autopsy that may have a direct bearing on persons who are or may be suspected of complicity in causing the death. In a given case, it may be more important to ascertain facts about the circumstances of a death than to have a minutely detailed description of the anatomical condition of the body. Thus, in medicolegal pathology it is more important to determine that a bullet entered the back of the chest and passed out of the body through the front of the chest than to learn that the bullet struck the descending aorta but did not injure the heart. The pathologist who does medicolegal autopsies knows the importance of preserving and properly marking bullets from the body of a decedent, or of properly collecting various organs for toxicological analyses, or of making a paraffin glove to determine whether the decedent fired a gun immediately prior to his death. He is alert to the acquisition and preservation

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of facts and objects which may be of value as evidence.

The conduct of a postmortem examination, with the additional preparation and examination of microscopic slides, and the compilation of a complete report that will stand the exacting test of scrutiny in a court of law, is a process which takes the better part of several days. In addition, there is required in most cases an analysis of the blood for the presence of ethyl alcohol, and in many cases other toxicological tests may also be indicated.

The professional activities of a pathologist in behalf of the county or state government should be compensated at approximately the same rate that obtains in the ordinary pursuits and activities of the pathologist's practice. In other words, a pathologist should not be asked to contribute time to the activities of government without being granted appropriate compensation.

APPOINTMENT AUTHORIZED

None of the coroners of the 88 counties of Ohio is a pathologist. However, the law provides that a coroner may appoint a pathologist, as an assistant coroner, to perform the medicolegal autopsies. In several counties where there are large urban populations, the coroners have made such appointments. In most of those rural counties where pathologists do autopsies for the coroners, the pathologists are retained each time for a single case only. Thus, the coroner must consult a pathologist and arrange for the examination of the body after the death has occurred and after the investigation has already begun.

ADVANTAGES ENUMERATED

There are certain advantages in a situation in which the pathologist holds an appointment as assistant coroner and receives a regular salary from the county:

1. When an autopsy is required in a given case, there is a pathologist upon whom the coroner can depend to respond and to do a competent autopsy.

2. In many cases requiring investigation by the coroner, but in which an autopsy is not deemed necessary, the coroner can make a better investigation if there is a pathologist with whom he can consult.

3. When a pathologist enters into an agreement with a county coroner to do medicolegal autopsies, he is likely to make an effort to become familiar with this specialized field of pathology. Furthermore, with continued experience, his knowledge and ability in medicolegal pathology will increase.

4. In certain cases in which an autopsy should be done in order to establish whether an obscure death was caused by homicide, a coroner might not authorize an autopsy if he believed that the

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county commissioners would deem the expenditure for an autopsy unjustified. It is unfortunately true that some commissioners seem more willing to pay for an autopsy when a murder is discovered, than when the autopsy, in revealing that a death was not due to homicide, frees an innocent person from suspicion and possible prosecution. If the pathologist receives a regular salary from the county regardless of how many autopsies are made, the coroners will not hesitate to authorize autopsies in these problem cases.

5. The criticism that a coroner had ordered an autopsy in order to provide a pathologist with a fee could never be made if the pathologist were receiving a regular salary from the county.

NEED SUDDEN, CRUCIAL

There are doubtless a large number of coroners in Ohio that will not or cannot obtain pathologists as assistant coroners. In some cases this will result from the inability of the county commissioners to recognize the necessity of such an arrangement. Other coroners may be unable to find suitable pathologists in their own or in a nearby county. Others will feel that they have so few cases that such an arrangement would be unnecessary, but to these coroners it should be reiterated that when the need for a pathologist occurs, it does so suddenly, and it is frequently crucial.

Recognition of the necessity for a coroner to have the aid of a competent pathologist when required, and of the difficulty which some coroners have had in obtaining the services of the pathologist when the need arose, has led to an exploration of the possibility of establishing a mechansim that would insure all coroners of the assistance of pathologists as required. There are three medical schools in the State of Ohio, and these are centered in three of the principal geographic areas in the State. The medical schools have personnel and facilities for doing proper postmortem and toxicological examinations as a part of a coroner's investigation, and it is probable that the coroners in the counties surrounding each of these universities will be invited to utilize the services which the universities could render. Preliminary conversations with representatives of the three medical schools have indicated a desire to participate in this plan. However, the counties which elect to utilize the services must be prepared to pay the costs which would be involved. The arrangement would be entirely voluntary on the part of the county coroner, and no coroner would be urged to utilize the service if he did not wish to do so. On the other hand, with an assurance of this kind from the medical schools, no coroner would be able to avoid the responsibility of having a properly performed autopsy when one is

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indicated. The claim that a coroner was unable to obtain a pathologist to do an autopsy would no longer be valid, for the services of pathologists would always be available at cost through the three medical schools of Ohio.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since May 6, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ATHENS COUNTY
Robert W. Ballard, Nelsonville

BUTLER COUNTY
Benjamin Schneider, Hamilton

CUYAHOGA COUNTY
Frederick C. Badt, Cleveland
William D. Baker, Cleveland
Charles S. Becker, Cleveland
John W. Davis, Cleveland
Donald B. Effler, Cleveland
Philip G. Fulstow, Cleveland
William G. Gilger, II, Cleveland
William J. Gleckler, Cleveland
Louis Halle, Cleveland
Patrick F. Healey, Cleveland
Rose Herman, Cleveland
John P. Lenahan, Cleveland
Joseph J. Lyons, Cleveland
Charles Q. McClelland, Cleveland
Cornelius J. McGarvey, Cleveland
James T. Mayer, Manhattan, N. Y.
John H. Rentschler, Cleveland
William Sinclair, Jr., Cleveland
Willard C. Stoner, Jr., Cleveland
Florence T. Takacy, Cleveland

FRANKLIN COUNTY
Morris L. Battles, Columbus
Margot Deckert, Columbus
Leslie H. Gould, Worthington
James L. Kingsland, Columbus
Howard C. Lawrence, Columbus
Roslyn F. Pariser, Columbus
Abraham Towbin, Columbus
Robert P. Zanes, Jr., Columbus

GREENE COUNTY
Richard F. Bahr, Fairfield

HAMILTON COUNTY
Irvin B. Beren, Cincinnati
Robert J. Davis, Cincinnati
Herman O. Dreskin, Cincinnati
Stephen P. Hogg, Cincinnati
Harold J. Louis, Cincinnati
C. Marshall Lee, Cincinnati
Joseph L. Steinem, Cincinnati
Raymond R. Suskind, Cincinnati
James E. Verbryke, Cincinnati

LORAIN COUNTY
Howard A. Keiser, Lorain

LUCAS COUNTY
George M. Boyden, Toledo
James A. DeJute, Toledo
Cal S. Kellogg, Swanton (temp.)
Robert R. Knisely, Toledo
Henry Vogtsberger, Upper Sandusky

MAHONING COUNTY
DeForest W. Metcalf, Youngstown

MARION COUNTY
T. N. Caris, Marion
Hodge M. Eagleson, Jr., Marion
Robert E. Logsdon, Marion
Philip W. Smith, Marion

MONTGOMERY COUNTY
Harry K. Marks, Dayton
Joseph A. Mendelson, Dayton

RICHLAND COUNTY
Sigmund H. Smedal, Mansfield

STARK COUNTY
James J. Karam, Canton

SUMMIT COUNTY
George H. Bischoff, Akron
Eunice R. Carter, Cuyahoga Falls
Joseph W. Ewing, Akron
Moses A. Richardson, Akron
Frank R. Souers, Akron
Otto S. Steinreich, Akron

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The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

June 17, 1949—Alfred Adler, Columbus, Univ. of Frankfurt; Horace E. Allen, Toledo, Univ. of Minn.; Kenneth L. Allen, Cleveland, Stanford Univ.; Alan M. Avrick, South Euclid, Univ. of Minn.; Samuel L. Balofsky, Cincinnati, Tulane Univ.; Chester J. Bogucki, Toledo, Wayne Univ.; A. Waite Bohne, Columbus, Washington Univ.; Milton Brotman, Cleveland, New York Univ.; George M. Brown, Cleveland, Univ. of Oklahoma; Carl F. Buechle, Akron, Hahnemann Medical College; Arthur E. Burns, Cleveland, Meharry Medical College.

Henry J. Caes, Dayton, New York Medical College; Charles M. Clark, Jr., Cleveland, Univ. of Virginia; Frank P. Cleveland, Cincinnati, Univ. of Pittsburgh; Robert P. Crawford, Cleveland, Howard Univ.; Victor G. DeWolfe, Cleveland, Columbia Univ.; John J. Douglas, Canton, Univ. of Rochester; Irving Dreyer, Toronto, Univ. of Illinois; Edward J. Fadell, Toledo, St. Louis Univ.; Edward G. Forgrave, Columbus, Univ. of Buffalo; Noble O. Fowler, Cincinnati, Univ. of Tennessee; Charles R. Freeble, Jr., Columbus, Univ. of Pittsburgh; Raymond A. Gaffney, Cleveland, St. Louis Univ.; Thomas P. Glynn, Hamilton, Univ. of Minn.

Earl S. Hallinger, Jr., Cleveland, Hahnemann Med. College; William A. Hawk, Cleveland, Univ. of Pennsylvania; Earl C. Hershberger, Akron, State Univ. of Iowa; Leo B. Janis, Toledo, George Washington Univ.; Asa C. Jones, Jr., Lima, Washington Univ.; E. Camille H. Killian, Findlay, Univ. of Illinois; Howard C. Kingsbery, Lima, Univ. of Illinois; Frederick V. Light, Cleveland, Univ. of Arkansas; John R. Lofits, Jr., Wooster, Univ. of Arkansas; Arthur H. Loomis, Akron, Harvard College; H. D. McPherson, Racine, Univ. of Louisville; John W. Monahan, Fremont, Univ. of Illinois; Myron L. Pardee, Cleveland, Univ. of Rochester; Bernard J. J. Pavilonis, Cleveland, St. Louis Univ.

James G. Roberts, Akron, Univ. of Pennsylvania; Karl R. Schlademan, Lima, Northwestern Univ.; Gregor Sido, Toledo, St. Louis Univ.; Malachi W. Sloan, II, Dayton, Hahnemann Medical College; Arthur A. Tesi, Yorkville, Univ. of Louisville; Howard D. Trimpi, Cincinnati, Emory University; Myron Volk, Cleveland, Indiana Univ.; William J. Weaver, Jr., Lorain, Albany Medical College; Harold M. Wilson, Ravenna, Howard Univ.; Richard L. Zettler, Hamilton, St. Louis Univ.

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GYNECOLOGY—Intensive Course, two weeks, starting Sept. 26, Oct. 24. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 19, Nov. 7.

OBSTETRICS—Intensive Course, two weeks, starting Sept. 12, Nov. 7.

MEDICINE—Intensive General Course, two weeks, starting Oct. 3. Gastroenterology, two weeks, starting Oct. 24. Gastroscopy, two weeks, starting Sept. 26, Oct. 24.

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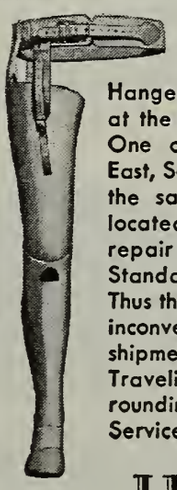
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American Medical Association Endorses CARE Book Program

The Board of Trustees of the American Medical Association at the annual session in Atlantic City voted to endorse the CARE program to send medical books overseas to war-ruined libraries.

The board also authorized the appointment of a committee of three physicians to study the program and to arrange for the cooperation of the A. M. A. in obtaining books and microfilms on medical subjects and funds for the purchase of such material.

Milton L. Smith, New York, educational director of CARE, explained that medical books to bring European doctors and students up-to-date on scientific and technical developments will be among the volumes sent to help replenish national and university libraries abroad.

CARE, through funds contributed for this purpose, will purchase books in this country according to requests already received from universities and libraries and will send them abroad. Contributors of more than $10 will be permitted to express a preference for the countries and institutions they wish to help.

Contributions to the book program may be sent to CARE offices in principal cities or to the CARE headquarters, 20 Broad Street, New York.

Cardiology at White Cross

Officials of White Cross Hospital, Columbus, have called attention to the fact that one of the residencies offered at that institution is in cardiology. This is a one year residency and can be used as a third year residency in medicine or as one year in cardiology and is only available to those who have had two years of residency in medicine. This information is supplemental to the article on hospital training facilities which appeared in the July issue of *The Journal*.

Veterans Administration

The Veterans Administration district office at Columbus has a vacancy for a board member (general medical officer) grade P-5, salary $6,235.20 per annum. Applicants must be graduates of recognized medical schools; must be licensed in a state or territory of the U. S., and must have had two years of progressively responsible professional experience in the field of medicine other than internship or residency. Maximum age is 62. Application should be made to the chief of personnel division, 52 Starling St., Columbus.

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Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
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Mrs. C. W. Kirkland, president of the Woman's Auxiliary to the Ohio State Medical Association, has announced the following schedule of fall district meetings:

District 1—September 27, at Cincinnati.
District 2—November 2, at Dayton.
District 3—October 15, at Marion.
District 4—September 13, at Port Clinton.
District 5—September 20, at Cleveland.
District 6—September 29, at Akron.
District 7—October 4, at Steubenville.
District 8—(Will be held in October at Lancaster; specific date yet to be decided.)
District 9—October 12, at Portsmouth.
District 10—October 17, at Columbus.
District 11—September 12, at Huron.

The Board of Directors of the Woman's Auxiliary to the Ohio State Medical Association held its first meeting of the 1949-1950 regime on June 21 at the Athletic Club in Columbus. Mrs. C. W. Kirkland, the new State President, presided. Following the luncheon, a stimulating talk was given by Dr. Carl A. Wilzbach, health commissioner of Cincinnati, in which he highlighted public education, school health and rural health.

FRANKLIN

Mrs. Oscar Jepsen of Canal Winchester has been elected president of the Woman's Auxiliary to the Columbus Academy of Medicine. Mrs. Robert M. Zollinger has been named president-elect. Other new officers are: Mrs. Emmerich von Haam, vice-president; Mrs. O. M. Goodloe, recording secretary; Mrs. William F. Lovebury, corresponding secretary; Mrs. Frank A. Riebel, treasurer.

TUSCARAWAS

A "go west" party recently was staged by the Tuscarawas County Medical Society and its Woman's Auxiliary for Dr. and Mrs. Walter Stager of Dover. The couple is leaving for Omaha, Nebraska, where Dr. Stager will head the anesthesia department of University Hospital. Table decorations with a Western flair were used. The guests of honor were presented with a book on travel through the West. Mrs. W. C. Roche and Mrs. R. A. Wilson led the group in singing western songs.

Gastroenterological Session

Dr. George Crile, Jr., of Cleveland will be among outstanding speakers at the National Gastroenterological Association's 14th Scientific Session at the Somerset in Boston, Mass., on October 24-26. Immediately following the Convention, on October 27-29, the Association is sponsoring a course in gastrointestinal surgery at the Boston City Hospital. Further information may be obtained by writing the secretary at 1819 Broadway, New York 23, N. Y.

Although he maintains a 60-hour work week, the average U. S. physician manages to wedge over one month of postgraduate study a year into his schedule. Practicing physicians average an equivalent of 20 days a year reading medical literature; eight days a year studying at medical schools and hospitals; and 6 days a year attending medical conventions.—*Medical Economics.*

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New Form of Ballot Will Be Voted on at Nov. 8 Election

Considerable interest is being shown by various groups in the proposed amendment to Ohio Constitution to provide the so-called Office Group Form of Ballot in place of the present Party Column Ballot in Ohio.

The proposed amendment, to be voted on at the November 8 Election, would be a new section to the Constitution of Ohio providing (1) that an elector may vote for candidates only by separately indicating his vote for each candidate; (2) that names of candidates shall be arranged in a group under the title of the office, with an indication as to each candidate of the name or designation of his party (except in the case of Party Primary Elections and Non-Partisan Elections); (3) that names of candidates for each office shall be arranged in rotation.

This Office Group Type of proposed Ballot is now in use in Massachusetts, New York, California, Colorado and Oregon and the proposal is thoroughly non-partisan.

Those who are promoting the proposed amendment insist that it would encourage independent selection as between candidates for various offices who would be grouped under the designation of the office itself, whereas opponents declare it would largely destroy party unity and responsibility.

Science Meeting

This year's 116th meeting of the American Association for the Advancement of Science in the Pennsylvania Zone hotels of New York City, December 26-31, is expected to have the largest attendance in the association's 101-year history, officers predict. All 17 sections and subsections of the A. A. A. S. and some 53 affiliated societies will have programs. Further information may be obtained by writing the association at 1515 Massachusetts Ave., N. W., Washington, D. C.

COMING MEETINGS

American Congress of Physical Medicine, 27th Annual Scientific and Clinical Session, Cincinnati, September 6-10.

A. M. A. School Health Conference, October 13-19, Hotel Moraine, Highland Park, Ill.

National Society for Crippled Children and Adults, Annual Convention, New York, November 7-9.

Ohio Society of Anesthesiologists, Annual Meeting, Akron, September 23-24.

Sixth Councilor District of Ohio State Medical Association, Annual Postgraduate Day, Youngstown, November 30.

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Mortality statistics compiled for 1947 show that tuberculosis death rates have again declined in the United States. In 1947 the rate was 33.5 per 100,000 as compared to 36.4 in 1946.

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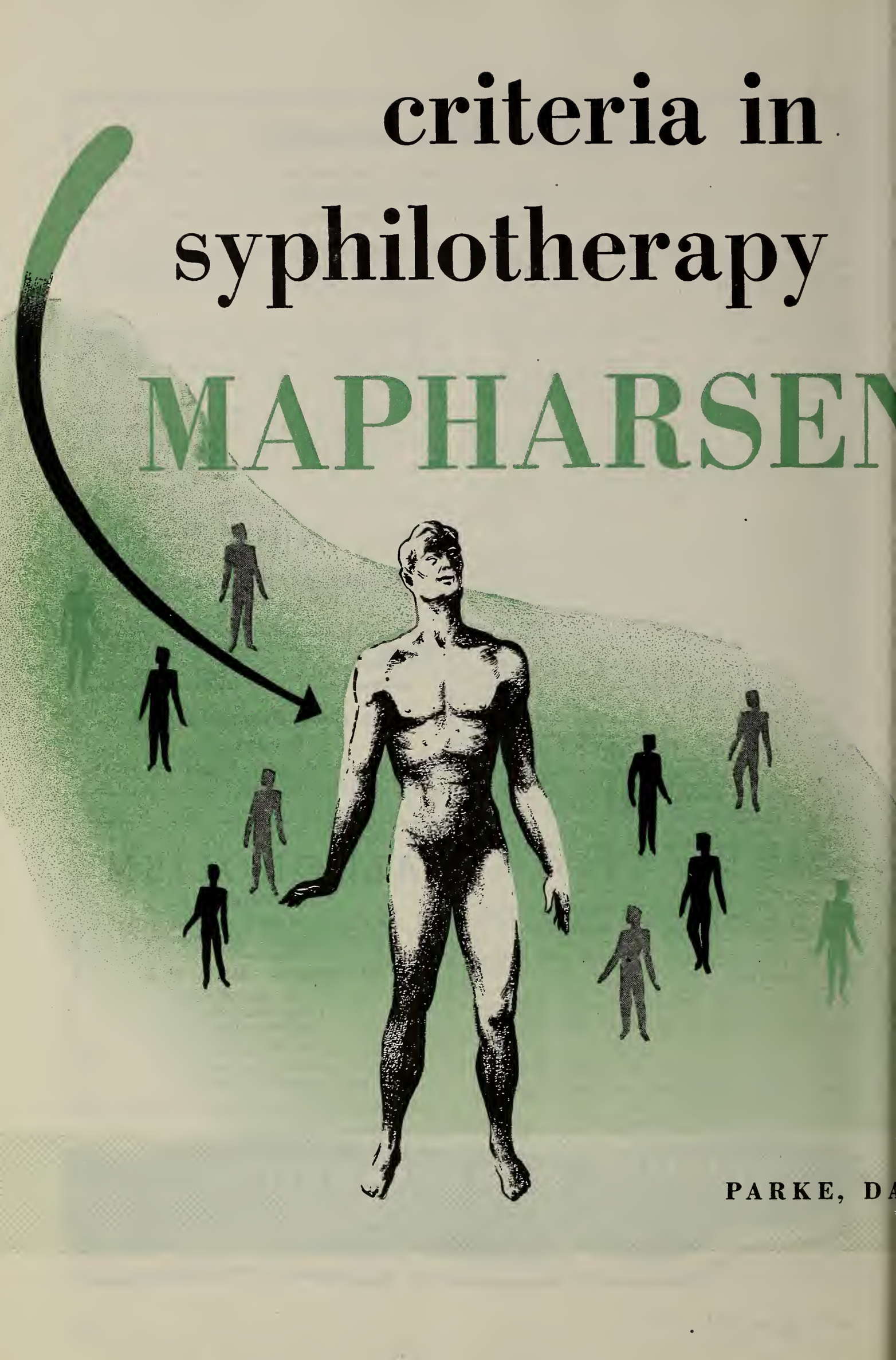
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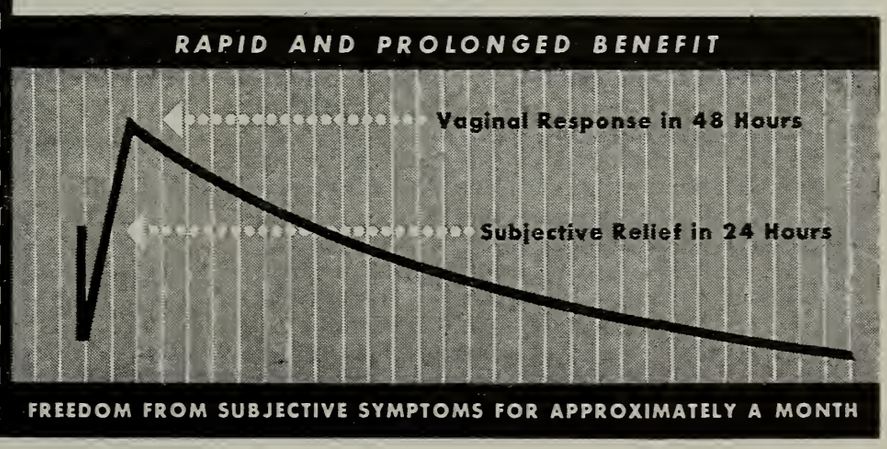
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The Physician's Bookshelf

By Jonathan Forman, M.D.

Our Civilization Rests Upon the Family

MOST of us physicians would like to make a sharp distinction between *public* health and *personal* health. Public health is sometimes confused with the health of the public—with the state of the health of the individual citizens when averaged up. We are very sensitive to the danger of the public health officer getting over into our field of private practice of medicine. Nevertheless, there are educational jobs which he should be doing—doing much better than he is. These are such jobs as mass education concerning health problems towards the solution of which he can best condition the minds of our people. The real job of teaching health belongs to those who are trained to teach. The public health officer and the private physician should insist that the schools use their trained personnel to do health teaching. Neither of us should encroach upon them.

Enough figures have been collected to show that something is wrong in the family life of America. The typical American concept of what is wrong here has been accurately summarized by the editor of the *New England Journal of Medicine*, under the title of "The Epidemiology of Morals."

> "Most very young women dream about the future. They plan to marry. As a young lady recently said to her father who was chiding her about a poor school report: 'You don't need a diploma to get married.' Most young men, it should be admitted, do not know what it is all about when they get married. The question, if not actually popped by the girl, is by pressure or contrivances put in the young man's mouth. In short, if he knows what he's doing, the young man is not in love. Marriages for sex alone soon pall and quickly fall apart. Marriages for children alone, after some years, find the mother without a job when her offspring are grown and in college or off on careers or marriages of their own, while a middle-aged father, aware of his failing powers, looks for a corn-haired sweetie to restore his confidence. How many friends for whom we stood at the altar twenty-five years ago ask advice now because of a vague sense of cracking up and the accompanying melancholy, suggesting that one prescribe or approve a change of job, of locality, and especially of wife! This was one of the factors that made forty-five-year-olds so belligerent during the recent war. Contrariwise, not a few of the women approaching middle age, their tubes tied or the uterus removed on some pretext or other, have a sex eagerness not easily satisfied by their disenchanted husbands. With all its rationalizations, divorce often is really a very banal affair of the glands and other monkey business. Divorce may be cunning or slick or smart, but it is not very often intelligent. It is impulsive or instinctive; it may even result from an honest affair of the heart, but not of the educated or understanding heart."

Ralph Borsodi (**Education and Living**, Parts I, II, III, IV, $10.00, *Devin-Adair, New York City)* has made a more complete investigation into the number and nature of the problems that enter into our family relations than anyone else. Borsodi has painstakingly assembled all of the answers man had found for these problems. Each of these answers he has subjected to searching evaluation to see which can safely be classified as within "the biological norm" for man. It is his considered opinion that to be within the norm a family must consist of three generations. Children who are not permitted to learn from their grandparents miss a most important phase of their education and upbringing. Grandparents who are deprived of the pleasure of their grandchildren miss half of the value of human relations and grow old all too fast.

The family physician, consulting his own traditions and his best insights in human nature, admonishes to the best of his ability those committed to his care who are about to set out on the matrimonial voyage. The clergy, too, undertake marriage counselling. So do the attachés of our domestic courts and our social workers—after it is too late. The marriage is broken before they even hear about it. The premarital advice of the physician and many professional marriage counselors puts all the emphasis upon sex; the clergyman upon sex, or children, and only occasionally and more lightly upon family ties.

The shocking divorce rate is evidence of the existence of the problem. Judge John A. Sbarbaro of the Chicago Divorce Court (**Marriage Is on Trial**, $2.00, *Macmillan Company, New York City)* bases all hope for the future in teaching our young people how to choose their mates so effectively that they will truly become

life partners. After the honeymoon is over, sex becomes an accepted part of life and, though it is still vitally important, it is not the glamorous experiment it was at first. From here on it takes intelligent effort to build true companionship—the sharing of mutual interests and the development of new ones, admiration, affection—all of these unite to join a firm basis for a lasting marital relationship.

Judge Sbarbaro concludes that "no judge desires to see marriage after marriage end in his court. If he is to stop this continuous flow of our country's lifeblood, he needs help desperately. No institution is so well qualified to give him that help as the Church. I call on all faiths to awaken to this great opportunity."

The churches are trying to meet this situation. Many clergymen are taking special training in counselling and various groups are issuing books.

(**On Christian Marriage**, Complete Official Text of the Encyclical Letter of Pope Pius XI, 5 cents, *The American Press, New York.* **This Is Marriage**, *apply Grailville, Loveland, Ohio.* **Successful Marriage and Personal Adjustments**, 15 cents; **How the Church Helps the Christian Family**, 15 cents; **Marriage: 1949 Model vs. Christian Marriage**, 15 cents; **Successful Marriage and the Christian Family**, 25 cents; **How To Organize Lively Discussion Groups—A Guide for Leaders**, a series of tracts issued by *The National Council of the Protestant Episcopal Church, 281 Fourth Ave., New York City.)*

The perplexed man or woman who seeks relief from the pressure of our changing society often becomes confused and uncertain when they consider psychoanalysis as a way towards emotional security. Milton R. Saperstein, M.D., (**Emotional Security**—A Guide Toward the Solution of the Problems of Marriage, Family Life and the Complexities of Modern Living, $3.50. *Crown Publishers, 419 Fourth Ave., New York City)* attempts to show us in his recent book how the generally accepted principles of psychoanalysis are to be applied to emotional difficulties with emphasis on sexuality, marriage, and the changing family structure. In this connection, the famous Dr. Van deVelde whose **Ideal Marriage** most of us have in our library, has reissued his **Sex Hostility in Marriage** under a new title (**Sexual Tensions in Marriage**, Their Origin, Prevention and Treatment, $7.50. *Random House, Inc., New York City).*

Sex remains an important but secondary factor in the consummation of a happy and permanent marriage. Sexual tensions menace every marriage at some time. In many cases these threatening tensions arise more than once after periods of absence. These tensions must be recognized and understood. Here it is an understanding of the things involved—their presence and their nature. This Dr. Van deVelde helps us to do.

More recently several books have appeared which also try to make the married couple aware of these repellent forces. There is, for instance, Joseph L. Fox's book **How To Keep Happily Married**, $2.50, *Dorrance and Company, Philadelphia*, based upon hundreds of Domestic Relation Court records. This eminent lawyer insists that the rules of the game are simple and are such as appeal to the common sense. He feels that sex ignorance plays a great role, but above all he is convinced that each of the couple must appreciate that "happiness in this world is made up of minute fractions—the little, soon-forgotten charities of a kiss, a smile, a kind look, a heartfelt compliment, and countless infinitesimals of pleasurable and general feeling." In other words, all concerned must work at it. "The resolution of the neurosis," the editor of the *New England Journal of Medicine* points out, "is not by a life-long haggling in the economics of pleasure and pain, but by growing realization of individuality and devotion to another's good."

The Benges (**Win Your Man and Keep Him**, by Jean and Eugene Benge, $3.00, *Windsor Press, Chicago)* go back a little farther. It is a book by parents who are known for their book on office management and personnel work and is dedicated to their daughter.

Their experience in the field of human relations has taught them the inescapable truth that human ecstacy or woe usually can be traced to emotional maturity or the lack of it. They, therefore, in your reviewer's opinion, rightly emphasize the development of the personality. With a fully matured personality "you do not merely repeat wedding vows in order to get married—rather you get married in order that you can honorably carry out these vows" so you won't let your partner down.

F. Alexander Magoun insists in this connection that "mutual emotional maturity has been listed first as a criterion for a happy marriage because the personal observation of many competent people and the evidence of every sociological study has shown it to be by far the most important single factor contributing to a happy marriage." (**Love and Marriage**, F. Alexander Magoun, Professor of Human Relations, Massachusetts Institute of Technology, $4.00, *Harper & Brothers, New York City.*)

In his book, **A Research in Marriage** ($5.00. *Lear Publishers, New York City)*, G. V. Hamilton, the well-known psychobiologist, presents one of the few studies which are scientific and taxonomic in treatment. It deals with the intimate revelation of the experiences in marriage of 200 serious-minded Americans. His research sums up to an impressive indictment of what parents and society commonly do to the individual in their efforts to socialize the sex impulsions. "There is considerable evidence in

support of the possibility that in many families the sons and daughters are so affected by their parents that when adult life is reached no conceivable mode of prolonged and intimate relationship with a person of the opposite sex is likely to end otherwise than disastrously." We can't condemn marriage or assume that we need only to reverse a bad procedure in order to have a good one. Yet, only 13 of Hamilton's 200 spouses said that if free they would never wish to remarry.

Ranking alongside Borsodi's **Living and Education** as among the best books on marriage and family life that have appeared in recent years is **The Family of Tomorrow** ($3.50, *Harper & Brothers, New York City)*, by Carle C. Zimmerman, professor of social relations at Harvard University. Zimmerman feels that we are moving rapidly into a storm center of a great clash between the family system and cultural continuity. He concludes that "three-quarters of the problem of the modern family in relation to our civilization is a matter of recreating and impressing family value systems. . . . Science cannot make people civilized. However, it at least can tell them how they can make themselves civilized."

It all boils down to producing a race of emotionally matured individuals. Elsewhere, I have discussed the physical basis of such a program (**Soil, Food, and Health,** $4.50, *Friends of the Land, Columbus, Ohio)*. The place to begin is with good food grown on good soil. It will take a generation or two to upgrade our breeding stock to the place where the majority of our youths will again have stable nervous systems upon which to build emotional stability. The alternative is the internal decay of a great civilization.

Education for Professional Responsibility. A Report of the Proceedings of the Inter-Professions Conference on Education for Professional Responsibility held at Buck Hills Falls, Pennsylvania ($3.00. *Carnegie Press, Carnegie Institute of Technology, Pittsburgh, Pa.)*, presents the interchange of experience, and ideas by teachers in schools of divinity, medicine, law, engineering, and business. Underneath their efforts runs the common problem of developing in their students the spirit of service in a materialistic world.

The problem in medical education of the greatest importance is how to make the scholarly attitude persist throughout life, how to insure that the physician and surgeon will become and continue professional, not remain or lapse into the merely vocational or commercial. Finally, in this Republic, there is no ruling, leisure class. Insofar as our citizens will continue to control their government, they must do so in spite of the demands of their work.

Medical Etymology, by O. H. Perry Pepper, M.D. ($5.50. *W. B. Saunders Company, Philadelphia, Pa.)*, gives the history and derivation of medical terms for students of medicine, dentistry, and nursing. A useful volume in these days when most of our students have not studied Latin or Greek. It is to be emphasized that this book is not a dictionary. It concerns itself more with the origin than the meaning of the word with which it deals.

Your Child Makes Sense, A Guide for Parents, by Edith Buxbaum, Ph.D., with a contribution by Florence L. Swenson, Ph.D., foreword by Anna Freud ($3.25. *International Universities Press, Inc., New York City)*, comes out of the New School for Social Research from a pupil of Freud. It is not difficult reading and it is stimulating. It may help to give parents an over-all point of view from which they can discern that their "children do make sense"—a thing they often fail to understand.

Health Services in England, by R. C. Wofinden ($2.50. *John Wright & Sons, Ltd., London, Williams & Wilkins, Baltimore, Maryland)*, is the Joseph Rogers prize essay for 1946 for the best "essay on the treatment of the sick poor of this country and the preservation of the health of the poor." This essay covers every legislative Act of Parliament for the past 300 years. It emphasizes that health and medical treatment cannot be studied in isolation. Therefore, emphasis is placed on social pathology. Rightly, too, the author points out the danger of losing sight of the welfare of the patient in the welter of contending factors in the British society today.

Syphilis: Its Course and Management, by Evan W. Thomas, M.D. ($5.50. *The Macmillan Company, New York City)*, brings us up to date. This disease, the author points out, is changing in its public health importance and its capacity to injure human beings. It is a concise summary of the situation in which the medical man finds himself after ten years of intensive therapy and five years of the use of antibiotics.

Nutrition and Diet in Health and Disease, by James S. McLester, M.D. ($9.00. Fifth Edition. *W. B. Saunders Company, Philadelphia)*, has been revised to include the results of war-time research in nutrition. Much new information about vitamins has been included and protein has been given greater emphasis especially in the feeding of the sick and injured. In all, it is an up-to-date and valuable work.

The Failure of Technology, by Fredrich Geng Juenger ($2.75. *Henry Regnery Co., Chicago)*. Perfection without purpose. Everyone should read this essay to find out why our technical progress has outrun our advance as morally and spiritually responsible human beings.

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Psychosomatic Orientations in Obstetrics and Gynecology

DWIGHT M. PALMER, M.D.

THERE seems to be an increasing awareness of the importance of psychosomatic orientations in all branches of medicine. In recent years several authors have pointed out the magnitude of the sociological and psychological factors in obstetrics and gynecology. The present viewpoint is that we need to add these factors and mechanisms to the physical and chemical ones that are already known, in order that we have a truly psychosomatic orientation. Fallas in introducing a symposium on Psychogenic Factors in Obstetrics and Gynecology said, "It is an attempt to offer some fundamental information and points of view for approach to the problems that we must all face with increasing frequency, so that we may more efficiently offer help . . . . that can never be achieved by drug or surgery, but only by understanding." The need in your field appears to be great. Bryson in a study of 4,000 private gynecological cases, concluded that over 1,200 were definitely "functional" in character, and that over 1,200 more had a psychosomatic background. She felt that these latter cases needed the services of a gynecologist with psychiatric orientations rather than treatment by a psychiatrist.

In using the term, psychosomatic, we refer not to a limited conception of a few conditions, but to all of medicine, in which the interrelationships of mind and body are expressed as a unit —the patient. We are not concerned with mind or with body as separate entities and we are not investigating the influence of one over and against the other. Rather, we are interested in the total organism and all of its phenomena, and that includes thinking as well as behavior.

Thus, we would like to consider the diseases which are peculiar to the female against the background of the entire female person and gain some understanding of the common backgrounds of the diseases and the mental processes which accompany those diseases. Again, it should be emphasized that we are not trying to find mental processes that cause diseases, or diseases that cause the mental processes, but instead we are looking for the deeper common backgrounds of both. These deeper mechanisms operate out of the total feminine personality which is our main consideration here.

There is a great need for further research in this area of medicine. Many of our present formulations are tentative, and our various hypotheses should always be subject to readjustment or to rejection.

It should be emphasized at once that there is no such thing as a typical female personality. There are many varieties of female personality just as there are many varieties of male personality and no one person can be said to be typical.

Read before the Section of Obstetrics and Gynecology of the Montgomery County Medical Society, February 16, 1949.

The Author

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BACKGROUND AND VIEWPOINTS

The modern conception of all human beings, both male and female, is that they are essentially bisexual and that it is a preponderance of one

set of sexual characteristics which determines either maleness or femaleness. This concept of bisexuality, as a potential mechanism, is supported by various studies including endocrine determinations. Thus, we look upon individuals as relatively feminine or markedly feminine, or fairly neutral, or relatively masculine or markedly masculine. It is to be emphasized that even those who are considered either markedly masculine or markedly feminine still have some of the characteristics of the opposite sex. This phenomena of bisexuality apparently goes back to the original undifferentiated gonadal state of development. Out of that immature physical stage with its accompanying undifferentiated physiological reactions, there emerges either the male or female personality. The factors that are at work in psychosexual evolution are both organic and socio-psychologic. The organic factors have their own internal dynamics and tend to differentiate the personality in the appropriate direction. Psychological factors may facilitate this organic determination, or may oppose or retard it.

The average feminine personality is characterized at the psychological level by two phenomena. These are narcissism and masochism. These qualities or characteristics are also present in males, and in variant female personalities but to a lesser degree. They are likewise observed in developing children of both sexes. In other words, it is not their presence but their preponderence which is characteristic of the average female.

Very early in her development, the female becomes a fixed focus around which maleness revolves. This fixation and centering of the female in the scheme of interpersonal relationships stabilizes her narcissistic position. Regardless of what males may protest to the contrary, the female is the dominant sex, and is the essential carrier of the stream of life—the mother of the species. Thus, she is placed in the central position where she may attract and reject the opposite sex, and where she may be stabilized in a supported position as she carries out her role of motherhood. Thus, passivity characterizes the female position. However, this is not a useless passivity but one that accomplishes its goal by drawing the male toward the female and utilizing him for her purposes. The female reacts to her absence of aggressiveness, to her subjugation by the male, to her protracted industry in motherhood and homemaking, by the quality of masochism. Deeper in her unconscious, the phenomena of masochism may be related to an envy of the male and a feeling of inferiority which forces her to a painful submission. In any event, the female position is masochistic as well as narcissistic in the scheme of human living.

The use of stages to describe the evolution of any personality should be regarded as arbitrary subdivisions made for the purposes of breaking down the material for specific purposes. Each of these s ages is like an individual frame of a strip of movie film, and each has meaning in the total perspective, only when it is fused with the preceding or succeeding stages.

EARLY CHILDHOOD

The early childhood of the female is marked by envy and by a fearful comparison with the male sex. These reactions can be intensified, or on the other hand they can be alleviated, by the parental relationships which exist at that time. The well-adjusted mother who is happy and content in her maternal role can have a beneficial effect on the little girl. On the other hand, the poorly adjusted mother can even at that early period impress upon the little girl the ill fortune of a feminine existence.

PREPUBERTY

This period in the life of the girl is marked by increased activity which serves to mobilize her intellectual and artistic talents, to raise her affective hopes and to give her new identifications. In other words, she is growing up and striving toward independence. The little girl of eleven, or thereabouts, lives in a world which is situated between childhood and adulthood. During this period, the girl attempts to make new identifications to take the place of some of those which she has formed with her mother. These previous identifications may be either with the good or bad qualities of the mother, as the little girl has seen them. The more unreal fantasies of younger childhood are replaced by more adult and more real fantasies. The girl will very likely try to be older than she really is, to imagine herself doing many things that older persons do, and she may imagine herself to be accepted by many older people. This usually necessitates her having many secrets which include not only some of her thoughts but some of her imaginative ideas of what older people tell and do. The easiest method that a girl can use at this age to gain independence, is to attach herself to another girl. The girl's mother may find this very undesirable but she will have to realize that the girl is trying to grow up. However, the girl at this stage is merely toying with life and has a very ambivalent relationship to her mother, and although she may tend to renounce very actively her mother for another girl, she still feels insecure without maternal protection. In summary, prepuberty can be looked upon as an offensive preparation for puberty for then the girl must either accept or reject the feminine role. The little girl is trying to find some sense of security with other females, and to experiment with life before she finally enters into the battle of puberty

in which she must either accept or reject her feminine models, which for the most part are from her mother.

PUBERTY AND ADOLESCENCE

During this period, the girl's ego must acquire independence and this is accomplished by dropping the old emotional relationships of the earlier years. In order to discard these former relationships, she must first devaluate them and this involves an underestimation of the parents which the latter may easily misunderstand. The girl must do this before her ego can grow and add to her already expanding narcissism. The narcissistic position gives the girl stability and self-confidence at a time when she is shedding her older identifications, and when her new ones are as yet incompletely accepted. During this time, she is likely to be quite erratic and to be subject to crushes; feeling at times that others are madly in love with her, at other times having the crushes herself, and at still other times throwing her energies into ideas and ideals which may become quite philosophical and altruistic.

During all this time she is facing the battle of making a final identification with either masculinity or femininity. The acceptance of identifications along these lines bring with them certain super-ego or conscience requirements and these may bring her into marked conflict with the reality needs of her situation. Thus, a girl is really caught between two opposing demands; one, that she give up her bisexual uncertainty, and the other that she attempt to orient herself in a feminine fashion toward heterosexual attachments. During this time, her biological and endocrinological processes are driving her toward this latter orientation.

Day dreaming and fantasy life are an important part of adolescence and girlhood. There is nothing harmful in this if it is not carried to an extreme. However, we see the type of girl who denies and sublimates all of this fantasy life, and who, as a consequence, becomes highly intellectual, or becomes the masculine, athletic type. On the other hand, there are girls who abandon themselves to fantasy existence and who become either neurotics or withdrawn schizoid personalities.

Girls more than boys are able to idealize their sexual feelings. However, these externalized, spiritual and emotional feelings are in conflict with sexual drives which take a narcissistic and passive character. In other words, her idealism is opposed by her inherent desire to be loved. Thus, it can be seen that the adolescent girl is a matter of paradoxes and conflicting emotions and actions.

MENSTRUATION

Menstruation is a most interesting psychosomatic problem. Among primitive peoples, the menstruating woman was and is considered dangerous and dirty. At the menstrual period women are often given the same powers that have been assigned to witches, such as ability to blight crops, to cause animals to miscarry, to cause milk to sour, etc. Many of the tribes in the South Seas force their women into seclusion apart from the tribe during the menstrual period. It is quite probable that similar prejudices concerning menstruation exist in the unconscious of almost everyone, men and women alike. It is the persistence of such ideas that make it difficult for women to discuss menstruation with each other and especially for the mother to talk about it with her growing daughter. The imparting of information by the mother to the prepubertal girl is usually justified, but the enlightment does not guarantee a healthy emotional attitude in the daughter. This is true because the girl who rejects the mother will also reject her information. In such cases the enlightment will only be at an intellectual level, and it will have no affect upon the girl's emotional and unconscious attitudes.

The later reactions of women to the menstrual period may be based upon conditions which are laid down at the time of onset of the menses. Women who later become ill and find it necessary to go to bed each month are often conditioned to that type of behavior by having received excessive care during their early periods. Women of a distinctly different type and who were aggressive toward their mothers may in later years be unusually irritable during the menses as an expression of the frustration of their feminine dissatisfactions. Thus, the menstrual period may symbolize either a desirable or a very undesirable happening. Therefore, one type of patient may show relief and another type of patient may show anxiety, and still another type of patient may show shame at the time of menstruation.

SEXUAL MATURITY

There is no sharp boundary between adolescence and sexual maturity. Self-love or narcissism which characterizes the earlier developmental stages is continued into this period of maturity where it constitutes a desire to be loved. At the same time, and at a deeper level, there is also a defense, in the form of masochism, against the expected aggression of the male. It should be emphasized that this female characteristic masochism, does not imply a state of inactivity or of sterile emptiness, but a phenomenon in which it is desired that activity be directed toward the personality which in turn denies aggressiveness. Therefore, we look upon masochism as rejection of aggressive external activity, and not in terms of the pain and suffering

which is implied by the use of the word in discussion of the neuroses.

The normal woman needs to experience deep love to satisfy her narcissism and also her masochism. If she is loved sufficiently she merely submits to aggression and foregoes it herself.

Many women show a masculine reaction either as a protest or out of fear of aggression. This masculine reaction may take the form of the female intellectual, the female worker, the female reformer, or such asocial avenues as prostitution. Such women are likely to be those who earlier suffered conflicts in their identifications with their mothers, and those who showed a lack of sister jealousy and an increased amount of father and brother identifications. Masculine women compete freely with men and attempt in every way to out-do them. Love enters but little into their lives. If they do join up with a man they seek out a passive, feminine type of male and completely overwhelm him. When the masculine woman comes into relationship with active men, there is always mutually aggressive conflict.

PREGNANCY

Pregnancy is accompanied by anxieties and by intensified introversion in practically all women. Also, many women have an activation of latent guilt feelings. Even early in pregnancy when the child is still a fantasy object, it is the focus of much interest and attention. These pregnancy reactions may be based upon childhood fantasies and activities in part, but a deeper and more powerful source of the feelings lies in the relationship of the pregnant woman to her own mother. In every instance, the capacity for motherhood is related to the identification with the mother. The mother-to-be has to find some compromise between her deep unconscious identification with the child which is directed toward the future and her identification with her own mother which is directed toward the past. If either of these identifications is rejected, difficulties arise; if she rejects the child, it becomes a hostile parasite, if she rejects her mother, her capacity for motherhood is weakened.

THE MENOPAUSE

This is a very critical period in any woman's life and the psychological reactions to this organic decline is one of the most difficult tasks that a woman faces. The individual variations in the psychologic picture depend almost entirely on the previous personality of the woman. At the menopause, the woman's narcissistic personality patterns are threatened by forces which can be best described as partial death. She has ended her existence as a creator of new beings and has reached her natural end as a servant of the race in its drive for preservation. She is now engaged in an active defense against her involution.

The threat of the oncoming menopause stirs up many defensive reactions which often take the form of increased activities and interest. These are an offensive blow which serves as a defense against the sense of defeat which the oncoming menopause denotes. Many of the conflicts and fantasies of puberty light up again in the menopause; for example, homosexual trends may become apparent.

Almost every woman in the menopause is depressed for a shorter or longer period. It seems undoubtedly true that women who are truly feminine have a milder reaction than the masculine-aggressive ones. Naturally the preceding life experiences of these two classes of patients will have had a marked effect upon them and will influence their menopausal reactions.

POSTMENOPAUSAL INVOLUTION

The aging person of either sex has to maintain a feeling of being socially useful and economically stable. This is more difficult for women than for men, and even more so for women who have never been employed outside of their homes.

Thus, grandchildren represent a valuable focus for the older woman who may be plagued with a feeling of being superfluous. The little ones bring back memories of her own children but now she can give them more attention than she could when she had a husband and a home to care for. And she can temper or avoid discipline, and perhaps "spoil" them.

Further aging in both sexes is characterized by declining interest in the outside world, an increase in selfish and personal matters, and a disregard and resentment for the opinions and activities of others. Paranoid attitudes are not uncommon. The appearance of long repressed hostility against the husband or some or all of the children is not unusual. This is due to the dissolution of the Ego and it may cause severe family disruptions. The breakdown of Super-Ego patterns may result in the appearance of thinking and behavior which is quite at variance with past conduct. Further involution may be marked by the appearance of facetious evasiveness, untidiness, and the hoarding of worthless objects. Finally, hallucinations and bizarre delusions may become prominent.

CLINICAL CONDITIONS

Dysmenorrhea. The condition of menstrual pain is one of the most common of gynecological disorders, and there are many factors in its etiology. Two points may be emphasized here. First, in instances where the cause is really somatic, the complaints must nonetheless be evaluated against the background of the patient's personality. Secondly, dysmenorrhea may be primarily socio-psychologic in origin. Thus,

all cases of dysmenorrhea need a psychosomatic evaluation.

Dysmenorrhea is subjective in nature and the subjective response is an indicator of personal security and satisfaction. Internal conflicts may find expression in menstrual complaints.

Early conditionings and psychosexual trauma may result in dysmenorrhea. The condition may also represent the rejection of femininity by the masculine type woman. Some girls and young women need education and emotional growth to overcome the early conditionings to menstruation as an "unwell" or "sick" period. Novak stresses "a policy of sympathetic understanding, reassurance, and education."

Amenorrhea. Here is another condition in which there are many somatic etiologic factors. However, it is also apparent that the causation may be partially or entirely at the psychic or symbolic level. On the one hand we see the woman who is intensely anxious for pregnancy, and who may show amenorrhea, or even pseudocyesis. On the other hand, there is the woman, married or more often unmarried, who fears pregnancy, and is often beset with guilt about her activities.

Studies entitled, War Amenorrhea, indicated that psychological factors played a definite part in causing amenorrhea under the stress conditions of World War II; exceeding even nutritional factors in importance.

Leukorrhea. While it is undoubtedly true that somatic factors are accountable for the great majority of vaginal discharges, it is also possible that the condition may serve as a defense against sexual intercourse. The mechanism may be an autonomic dysfunction similar to that responsible for mucous colitis.

Frigidity. This condition has a very high incidence (estimates vary from 40 per cent to 75 per cent), and there are several varieties of contributing factors. The paramount etiology is emotional immaturity with incomplete or partially incomplete resolution of the early childhood complexes (Oedipus and castration complexes).

Frigidity most often represents a rejection of the pleasure of intercourse because of Super-Ego or conscience requirements. The Super-Ego may demand this price for having relationships with a father figure.

Frigidity may also be due to the presence of other erotic fixations such as homosexuality, perversions, etc. It may also be a reaction to certain forms of ascetic idealism, such as the conditioning of a girl to regard intercourse as "dirty" and men as "bad." Finally, the "maternal type" of woman may suppress and repress her sexual pleasure in an over-played masochistic, martyr-like role.

Sterility. There are many psychological motivations for a woman to have children. These include such basic feelings as immortality and the defeat of death in parenthood, thus facilitating narcissistic motivations. Also, certain religions and certain folklore have impressed the idea that the childless woman is inferior. In the past, it has been almost universally accepted that the responsibility for the sterile marriage lay in the wife. Primitive people often held such women to be subject to a curse and more modern civilizations have looked upon her as some sort of a cripple. Modern scientific advances have shown that it is often the husband who is at fault and this discovery makes possible the release of various aggressor reactions against the sterile husband. The ability to release these aggressions have helped the sterile woman. This is true because otherwise the sterile woman would often look into her own background for the supposed cause of her sterility. If she does she may select various guilt-laden activities of the past and assume that they are the cause of her present difficulty. Many women become chronic neurotic sufferers on this basis and gain a lot of unconscious satisfaction in spending their sterile husband's money doctoring other neurotic disabilities which are substitutes for their basic childlessness.

Spontaneous Abortion. Psychological factors in spontaneous abortion vary from excessive narcissism which rejects the threat of the distortions of pregnancy to the failure to want a child from an unloved mate.

Induced Abortion. The psychological picture in induced abortion is a complicated one. The abortion interferes with the basic unconscious drives for motherhood and while, at a superficial level, it would seem that the abortion offers the prospective mother freedom and a certain escape, it is in fact not so simple a solution in many cases. While it may solve the social conflicts, it does not solve but rather injures the basic motivations. In the deeper psychology the feeling is not so much that the patient has destroyed another individual or a child but that she has destroyed a part of herself. Due to the fact that the woman is asked to destroy something which is fundamentally of great value, she may shift her guilt feelings into aggression against her partner, particular if the abortion was sought to aid him in some way. After the induced abortion, she has a feeling that she is not the same as before. This reflects a definite threat to the woman's basic narcissism. Guilt feelings following an abortion may lie dormant for many years. In fact, they may never appear in any concrete form. However, if the woman later gives birth to a defective child, it will almost invariably follow that she will relate defectiveness of the second child to the guilt of the previous abortion. Furthermore, it is not uncommon for women in the menopause to bring to the

surface feelings of guilt concerning abortions that they have not consciously thought of for many years.

Promiscuity and Prostitution. These are complex social problems with divergent etiologies, but the psychological factors are of major importance. Most workers agree that the majority of women who are promiscuous are psychosexually immature, and more often than not, frigid.

Some of these women are continually acting out remnants of unresolved father complexes; others are seeking to master and humilate men on a basis of envy. Still other women, basically selfish although more mature, are motivated by money, pleasure and a rejection of the sacrifices of marriage and motherhood.

Nausea and Vomiting of Pregnancy. In the study of these phenomena the question of etiology has received much attention. Some authors have found psychological motivations in unconscious wishes to avoid pregnancy, which motivations are often covered by a conscious wish for pregnancy. Other investigators have felt that the nausea and vomiting may be a reaction to guilt feelings and that the misuse of the upper gastro-intestinal tract may reflect the operation of childhood phantasy formations regarding oral impregnation.

Robertson rejected these conceptions and stated that he found a high incidence of frigidity in those so afflicted, that they had undue mother attachments and a heightened sense of disgust concerning both coitus and pregnancy. The earlier occurrence of "dyspepsia" was also a contributing factor. He emphasized that each patient should be studied as an individual.

Psychoses of Pregnancy. The incidence of mental disorders among pregnant women is said to be twice as great as that among the female population generally. However, it is not believed that there is any psychosis that is characteristic of pregnancy. The prevailing viewpoint is that pregnancy imposes nutritional, endocrine, sociological and psychological stresses on the pregnant woman, and that some women break down due to the interplay of pre-disposition and stress; but that no psychotic break is specific for pregnancy or its sequelae. Most writers feel that the psychological factors are of the greatest importance. Pregnancy may be a threat to narcissism beyond the limits of tolerance. It also forces the woman who has had difficulty with mother-identifications into the maternal role. Her non-acceptance may demand a splitting off of her affective life from her reality position. Guilt feelings may be activated, as may anxiety feelings concerning the pain and dangers of labor.

The coming child may be a threat to the woman's freedom and economic security. It may serve to bind her through her conscience to a worthless or unloved mate.

Mental breakdowns in the puerperium may be complicated by toxic and depletion factors, but they also may be free of those etiologies. Such puerperal psychoses most often represent a rejection of the maternal role.

CONCLUSION

Every female who becomes an obstetrical or gynecological patient is entitled to complete evaluation and management. Such an orientation to the subject may be termed psychosomatic. This procedure entails no lack of emphasis on the somatic aspects of her case, but does require that the sociopsychological aspects be considered in addition to the physiochemical factors.

This paper gives a brief account of some of the sociological and psychological orientations in the field of obstetrics and gynecology.

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New Concepts in Management of Cerebral Palsy

For many years we have seen the entire problem of cerebral palsy viewed in a completely hopeless light. With the realization that all of these children were not feeble-minded and that they could be treated, there has developed, particularly in lay groups interested in crippled children and in the lay press, an attitude that these cases can be cured.

To me, this is an even more cruel tendency than saying there is nothing to do, for it raises the hopes of parents only to certainly drop them to greater depths. This can best be prevented by a realistic outlook of what may be expected.

Yes, if he has a normal mentality, the child can be taught many things—possibly to walk, to dress, and feed himself, to speak understandably. To be normal—No, but certainly far better off than without these accomplishments.—Weston Cook, M.D., The Journal of the South Carolina Medical Association, Vol. XLV, No. 8, August, 1949.

Torsion of Spermatic Cord: Case Report

LEO J. SZARY, M.D.

TORSION of the spermatic cord is a twisting of the spermatic cord and testicle on its long axis resulting in partial or complete disturbance of the blood supply to the testicle and cord. There are two types, acute and chronic.

ETIOLOGY

The exact cause of torsion is unknown, however, many theories have been advanced. Practically every case of torsion of the spermatic cord may be catalogued under predisposing factors or exciting factors. Wolf[1] mentions the following predisposing causes: 1. Undescended and imperfectly descended testicle; 2. abnormally long postmesorchium and gubernaculum; 3. very roomy tunica vaginalis; 4. complete enclosure of the lower end of the spermatic cord, testis and its appendages in the tunica vaginalis; 5. long and loose connection between testicle and epididymis; 6. abnormal attachment of the mesorchium; 7. flat and broad cord; 8. congenital non rotation of the testicle; 9. anomalus vein to undescended inguinal testicle; 10. new growths of the testicle. Wolf[1] also mentions the following exciting causes: 1. Spontaneous; 2. muscular effort such as lifting heavy objects; 3. pedaling on bicycle; 4. straining at stool; 5. restraining while falling; 6. direct trauma to the testicle; 7. application of truss; 8. attempt to reduce hernia; 9. athletic events.

Torsion may occur at any age, Hegner and Postma[2] reported torsions in a four-month old infant. O'Conor[3] reported a case in a man 68 years old, but the average was 13.3 years in 124 cases. Abeshause[4] in 350 cases found the average age of 17.7, and the right and left side are equally involved.

SYMPTOMS

The symptoms vary with the position of the testicle and the amount of torsion present. The usual symptoms are severe pain in the scrotum radiating into the inguinal region, abdominal pain with nausea and vomiting. Shock, fever and leukocytosis may be present. Physical examination reveals slightly swollen elevated testicle. The testicle is tense and cannot be differentiated from the epididymitis. Attempt to move the testicle into the inguinal canal causes severe pain instead of relief as in orchitis and epididymitis.[5]

In the differential diagnosis one must differentiate torsion from acute epididymitis, orchitis, traumatic hematocele, hydrocele, strangulated hernia and neoplasms of the testicle.

Submitted March 15, 1949.

The Author

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TREATMENT

There are two procedures, manual detorsion without surgery and detorsion with surgery. Manual detorsion without surgery at present is only of historical interest. Surgical exploration should be carried out as soon as the diagnosis is made to determine the disturbance of the blood supply to the testicle and cord. If the circulation is re-established some form of orchidopexy of the cord to the wall of the scrotum should be performed. If the blood circulation is not re-established, orchidectomy with ligation above the torsion is the proper treatment.

CASE REPORT

Case History No. 6764D, St. Thomas Hospital, Akron, Ohio: L. F., a 16-year-old male, suddenly experienced severe pain in the scrotum and left inguinal region while diving off a swimming board at the Y.M.C.A. He immediately left the pool, doubled up and vomited a clear fluid. While riding the bus home he noticed that every jar the bus made increased his pain in the inguinal region and mid-abdomen. He vomited for the second time as soon as he arrived home. His parents summoned a physician who sent him to the hospital. The past history is essentially negative as the patient has been in excellent health.

Physical examination revealed a well-developed, well-nourished male, who appeared acutely ill. Patient complaining of pain in the abdomen about the umbilicus, also pain in the left groin. Abdomen moderately tense, left side of the scrotum and inguinal region swollen. Attempt to reduce what appeared to be a hernia only increased pain in the inguinal region and abdomen. The patient vomited during the physical examination. Attempted reduction under morphine sulfate gr. 1/6 failed.

A diagnosis of strangulated left inguinal hernia was made and the patient was prepared for surgery. Under spinal anesthesia of 100 mgms. of procaine, a left herniorrhaphy incision was made, but no sac was found. The upper portion of the cord appeared normal and the ring was closed. A moderately enlarged bluish mass appeared through the covering tunica vaginalis in the lower aspect of the incision. The mass was incised exposing a strangulated cord and testicle, the former being twisted four

complete turns. The testicle was drawn out of the scrotum and untwisted. Warm saline sponges were applied to the bluish black testicle and cord. In about four to six minutes the normal color returned as the circulation was restored. The testicle was replaced in the scrotum and the testicle was sutured to the tunica with interrupted plain catgut 00.

Surgery was performed five hours after the onset of symptoms. The patient made an uninterrupted recovery, left the hospital in five days and returned to school in two weeks. To this date, there is no evidence of atrophy of the testicle.

SUMMARY

1. A case of torsion of the spermatic cord is reported.

2. Acute torsion of the spermatic cord is frequently undiagnosed.

3. Torsion of the testicle and cord indicates immediate surgery.

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Anesthetics in Psychology

This subject dates back to 1905, to the work of Joseph Jastrow, of the Faculty of the University of Wisconsin, 1888-1927, where he made many contributions to experimental psychology.

It is my desire to suggest for experimental purposes, the use of gas anesthesia in psychoanalysis and in the treatment of dementia praecox. Psychoanalysis, dream interpretation plays a prominent part in the favorable prognosis. (This is held in doubt by some medical men.)

The conditioning of psychological brain processes can be influenced by the inhalation of a little CO_2 or the use of a small amount of pentothal sodium to give good hypnotic rapport. It is of interest to note that it is almost impossible for the patient to refuse to answer questions regardless of inhibitions. N_2O, ether, and chloroform might be of use in the promotion of dream phenomena. This is only suggested as a short cut and to be used in conjunction with accepted methods of mental analysis.

That carbon dioxide administered to patients suffering from dementia praecox has some temporary beneficial effects, has been demonstrated at the California University Medical School. Experiments conducted showed that a fleeting period of intelligence was obtained. These periods of sanity were brief, lasting from ten to fifteen minutes, but the patients were able to answer questions rationally or to exhibit recognition of his surroundings. This may be worth further study and experimentation.—JOHN H. ERNST, Ps.D., Toledo, Ohio.

The Story Behind the Word: Some Interesting Origins of Medical Terms

Carbuncle:—A term descriptive of the lesion. It is derived from the Latin, "Carbunculus," a little coal, from carbo or coal—a red, firey, round blotch on the skin.

Eczema:—A descriptive term literally meaning "I boil out." It is derived from the Greek word "ekzesis" which is composed of the words "ek," meaning "out" and "zeo," "I boil."

Goiter:—This term is derived from the French term "goitre" which in turn comes from the Latin word gutter or guttar, literally meaning the throat.

Hangnail:—What we call a hangnail should by rights be "angnail." The term is derived from the Anglo-Saxon word "ang" or pain. In common usage, however, the first syllable "ang" has been changed to hang probably because this sounds more plausible or comprehensible.

Venereal Disease:—The name venereal disease is derived from the sexual origin of these diseases. They are named after "Venus the Goddess of Love" and in ancient times were spoken of as "diseases acquired through the misfortunes of love."

Quinsy:—This term is graphically descriptive of the symptoms of the condition and literally means a "dog throttling." The term comes to us as a corruption from the old French term "squinance" and the old Italian term "squinanza." These terms derive from the Greek word "kunangche" composed of "kuon or kuna," a dog, and "angchein," to throttle.

Shingles:—A corruption of the old French term "sangle or cengle" which in turn is derived from the Latin word "cingulum" or girdle. The name is descriptive of the encircling nature of the lesion.

Whooping Cough:—A word imitative and descriptive of the character of the cough. The scientific name Pertussis, literally means "to thoroughly cough" and is derived from the Latin "per," thoroughly, and "tussis," or cough.

Schizophrenia:—This term is derived from the Greek words "schizo," I cleave, plus the Greek term "phren or phrena," the mind. Phren means the diaphragm or mind, as the ancient Greeks believed the mind to be situated in the diaphragm, hence phrenic—the diaphragm.

Sodomy:—A term of Biblical origin, an unnatural crime attributed to the inhabitants of Sodom.

Onanism:—Pertaining to the "Sin of Onan" or self-pollution. Onan was the son of Judah and in Genesis 38:9 we read "And Onan knew that the seed should not be his, and it came to pass, when he went in unto his brother's wife, that he spilled it on the ground, lest that he should give seed to his brother."

—HARRY WAIN, M. D., Mansfield, Ohio.

The "Tin Can" Nasal Splint

J. GORDON HIMMEL, M. D.

THE last two decades have produced an increase in automobile travel and with this increase, a concomitant increase in automobile accidents. Not the least of the sequelae of these accidents, in numbers, is fractures of the face and nose. During the same period of time, there has been an increasing incidence in the number of cosmetic surgical procedures of and about the nose. The most frequent procedure is the rhinoplasty, which has with it, fracturing of the nasal bones. As with all surgery, the immediate postoperative care is as important as the main surgical procedure, thus in fractures of the nose, either through accidents or through rhinoplasty, the splinting and immobilization of the bony fragments are very important in determining the final result.

The uniform pressure exerted over the entire nose, by an external splint, keeps the fragments in alignment, preventing their outward displacement and excessive callus formation. It helps prevent the accumulation of serum and blood in the soft tissues, thus averting marked swelling, hematoma and fibrous tissue formation.

INDIVIDUAL SPLINT

A commercial universal splint is sold as such, but it can never be as satisfactory as one made individually to fit the case on hand. The material used should be flexible enough to adapt itself to external changes occurring in the nasal shape during healing. The most common materials used have been stent, lead and copper. Stent is a dental compound; that is a wax compound which comes in thin square sheets. It softens easily in hot water and is easily molded on the nose. However, it has one disadvantage as an external splint—once hardened it retains a definite form and cannot be made to follow the changing contour during healing. Lead and copper splints are preferable because of their greater flexibility. Lead (gauge 18) is useful because it can be cut out directly on the nose without a preliminary pattern. Copper, being less flexible, and more difficult to adjust, requires a pattern for accurate shaping.

While working as a house surgeon at the Illinois Eye and Ear Infirmary, Chicago, the author came in contact with otolaryngologists who used the stent and copper molded splints and they appeared satisfactory and served their purposes. Dr. Adolph Brown of Chicago was a plastic surgery consultant at this institution and with whom this author was later associated; and he used successfully the splint which will be described.

Submitted August 27, 1948.

The Author

● Dr. Himmel, Cleveland, Ohio, is a graduate of Ohio State University College of Medicine, 1937; diplomate, American Board of Otolaryngology; member, American Academy of Ophthalmology and Otolaryngology; on otolaryngological staff, Mt. Sinai Hospital, Cleveland.

This splint is made of tin as cut from tin cans and it can be molded as well or better than the more expensive metals. The method of application of these splints is equally noteworthy because it is a method which not only keeps the splint in place but distributes even pressure over the whole nose. This is a material and a method of application that any physician can use in his office for nasal splinting.

MAKING THE SPLINT

Any clean empty tin can will furnish the raw material. A large can is preferable, because it can furnish more splints with the same amount of effort. Both ends of the can are removed by means of a can opener. Then, using a heavy shears, the seams are cut through and the

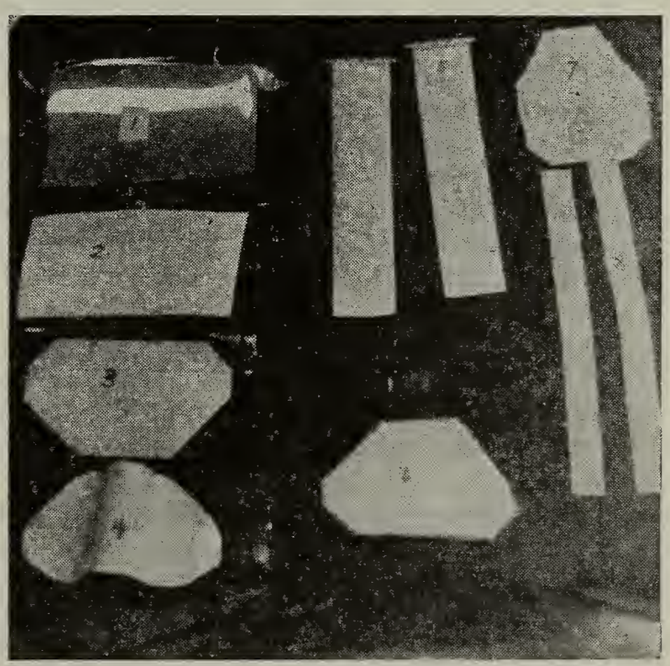


Figure 1. 1—Metal as cut from tin can; 2—Same piece covered with one layer of tape on each side; 3—Metal cut with scissors to fit nose, the upper part of the splint is the narrow lower end shown in the picture; 4—Splint shaped to fit nose and cheeks; 5—One-inch adhesive tapes with a portion of an applicator stick at one end; 6—A four-inch gauze square cut to fit the splint; 7—Piece of adhesive tape cut to fit glabella at the narrow end; 8—Strips of half-inch adhesive tape.

longitudinal seam is cut out. This allows the can to be stretched and flattened. Then both end seams are cut off. This leaves a large flat piece of tin. This is cut longitudinally down the middle leaving two long strips of tin. Then, rectangular pieces are cut, about 3½ inches long and 2¼ inches wide. (Figure 1, No. 1.)



Figure 2. The gauze pad and metal splint are in place; one narrow half-inch tape runs from the lower end of the splint to the forehead. The one-inch cheek tapes are in place.

The tin strip is covered with adhesive tape on both sides so that no wrinkles are present. (Figure 1, No. 2.) Then the corners are trimmed with a bandage scissors as in Figure 1, No. 3.

Two strips of one-inch adhesive tape and about 5-5½ inches long, are used. A wooden applicator stick is covered by ¾ inch of each tape and then the stick is cut so that there is a small end sticking out of each side. Figure 1, No. 5.

A piece of gauze or cotton lint, one layer thick, is cut in the same shape as the splint, excepting maybe 1 to 2 millimeters larger in all diameters. This will serve as a pad under the splint. Figure 1, No. 6.

A wide piece of tape, about 2¼ by 2 inches, is trimmed as is the piece, Figure 1, No. 7, for the forehead. Two strips of half-inch adhesive tape are used, each about six inches long. (Fiure 1, No. 8.) Also, a small rubber band is required, not shown in Figure 1.

METHOD OF APPLICATION

After the fractured nasal bones have been set, as desired by the surgeon, digital pressure is placed on them to press out any blood or serum which may have accumulated under the skin. Then the metal splint is bent in half so that the two ends meet and then the sides are flared out. (Figure 1, No. 4.) The bent sides are fixed so that they hug the sides of the nose quite snug, and the flare of the splint almost rest on the skin of the cheeks. Then the gauze pad is placed on the nose and the splint over it. A strip of the half-inch tape runs from the lower edge of the nasal splint to well on the forehead. The one-inch tapes are placed from just in front of and below the lobule of the ear, on the cheek, and far enough apart so that there is at least 1 to 1½ inches between the two ends over the splint. (Figure 2.)

A small rubber band is stretched over the ends of the applicator sticks and one-inch tapes, so that the rubber band is stretched over the splint and exerts pressure on it.

Another piece of the half-inch tape is placed around the rubber band to hold it in the middle of the splint and it also is brought to the forehead, stretched evenly over the first piece of tape on the forehead.

The large piece of tape, No. 7, is placed on the forehead over the other two half-inch tapes,



Figure 3. The rubber band has been stretched between the two cheek tapes over the splint. Another piece of half-inch tape is curled around the rubber band, centering the band over the splint, and then it is run onto the forehead. Over both forehead tapes, the wide piece of tape is placed to keep the other pieces from slipping.

to anchor them in place and keep them from slipping.

When thus applied, as in Figure 3, the splint will remain undisturbed for 2 to 3 days; after which the splint is removed; and if the edema is gone, the sides of the splint can be readjusted

to fit more closely. Also, the cheek tapes can be reapplied more closely to the center of the splint, so that the rubber band will be at less tension. After reapplication of the splint, it can be left undisturbed for five more days, at which time the nasal bones are usually united.

This nasal dressing can be worn with comfort and will not interfere with eating or movements of the head. The rubber band applies even pressure over the center of the splint.

SUMMARY

A nasal splint is presented which is very cheap to make and requires only a "tin can" and adhesive tape for raw materials. The method of application is shown, and it can be used by any physician interested in rhinoplasties or in setting traumatic nasal fractures.

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Hyperinsulinism

The concept that excessive secretion and action of insulin could lead to hypoglycemia with characteristic symptoms was first advanced by Harris in 1924 and since that time there have been numerous reports in the literature about hyperinsulinism. The discovery that a tumor of the islets of Langerhans was the causative factor led to remarkable surgical cures with rehabilitated patients. In some cases with a classical clinical picture no tumor could be found and partial resection of the pancreas has brought relief to many of this group, provided a tumor of the head of the pancreas or aberrant pancreatic tissue was not overlooked. Today, though the syndrome is not commonly found, we have a clearer knowledge of the problems associated with hyperinsulinism, largely due to the work of Whipple. Hyperinsulinism is a disturbance of the pancreas causing an overproduction or excessive action of insulin resulting in hypoglycemia. Except for the injection of insulin this must be due to excessive secretion by the pancreas. Though hyperinsulinism leads to hypoglycemia the two terms are not synonymous. Hypoglycemia may also be due to a variety of other causes with clinical symptoms, and moreover is often found without any clinical symptoms.

The symptoms are those of hypoglycemia and may be mild or severe. They will vary from hunger, pallor, palpitation, sweating, tremors and weakness all the way to maniacal or epileptic-like seizures of coma.—B. B. Landry, M.D., & J. E. Burns, M.D., Conn. State Med. Jour., Vol. XIII, No. 8, August, 1949.

KEEPING UP WITH MEDICINE

• It sometimes would seem wise to establish courses on teaching for the faculties of our medical schools. Only at the high school level, and below, is it thought necessary nowadays to impart the art of pedagogy to those who give instruction to our youth.

* * *

• Benjamin Rush has been called the first American psychiatrist. It was in 1796 that he at last achieved his ambition, when what he called a "mad-house" was opened in the Pennsylvania Hospital.

* * *

• In some series, at least, the passive transfer tests in all patients sensitive to ultraviolet light, have been positive regardless of the difference of their spectral range.

* * *

• Freud once said: "I have never known an eminently successful man who was not sure of his mother's love, and in the first analysis this means enough milk."

* * *

• A survey of the literature suggests that persons suffering from some allergic condition are more susceptible to reaction from anesthetic agents and drugs. The asthmatic patient presents the greatest problem because of the difficulty in breathing, increased pulmonary secretions, edema, and congestion.

* * *

• Persons who develop neuroparalytic or other reactions to rabies vaccine should be treated with antihistaminic drugs.

* * *

• The most common skin disease encountered in private practice is contact dermatitis.

* * *

• Good bowel habits begin in infancy where they can be taught with a little patience.

* * *

• One can expect little change in the level of cholesterol of the blood plasma by a reduction in the cholesterol intake.

* * *

• Addison described, just 100 years ago, the distinctive disease of the adrenal cortex which bears his name. This brilliant analysis may be said to have been the beginning of Modern Endocrinology.

* * *

• During the past two and a half years, considerable study has been under way in the administration of methyltestosterone orally to the premature infant—apparently decreasing the mortality rate or shortening the perod of postpartum prematurity.—J. F.

Bacterial Resistance in Relation to Combined Use of Streptomycin and Sulfadiazine

H. M. POWELL, Sc. D.

BIOLOGICAL immunity against infection comprises combined activity of both humoral and cellular forces, and the survival of a host species is evidence of the success of biological immunity in nature. Without entering into an elementary review of immunology, it is evident that most all sorts of anti-microbial actions are resorted to by a host, and no single type of response is depended upon exclusively.

With the advent of sulfonamide drugs and later of the various powerful antibiotics, much of classical immunology has lost its impelling interest since the final answers appear at hand, and otherwise fatal infections can be combatted successfully with considerable ease.

In immunology, however, there is still an open chapter on active biological immunity, especially active immunity attained artificially with considerable success with vaccines, toxoids, etc. There is also an open chapter on therapy of diseases caused by the smaller viruses, and here none of the final answers seem to be known. While it may be possible to prevent certain of these latter diseases biologically, their specific cure either biologically or with the known chemotherapeutic agents has not met with much success. Certain other diseases, for the moment at least, appear hopeless in respect both to specific prevention and cure. More study may change the outlook on these, however, and in these days one is reminded of the proverbial efficiency expert who did difficult things immediately, and impossible ones in the course of a very few days.

It is evident from the facts underlying the above superficial background that brucellosis has not been hit too squarely by specific preventatives or early and spectacular cures. The subject of prevention cannot be discussed here. The subject of the newer forms of therapy and possible cure of brucellosis, especially with streptomycin and sulfadiazine, prompts us to report on some similar tests in which lethal pathogens may be dealt with to measurable degrees of success by various combinations of antimicrobial agents, no single one of which is spectacular in effectiveness. These agents include biological and newer chemotherapeutic agents. It is realized that combined therapy may be a stop gap until single powerful specific agents may be found.

The Author

● Dr. Powell, Indianapolis, Indiana, is a graduate of Johns Hopkins University School of Hygiene and Public Health, 1923; member, Society for Experimental Biology and Medicine, Society American Bacteriologists; associate in microbiology, Indiana University School of Medicine; and head of bacteriology, Lilly Research Laboratories.

EXPERIMENTAL REVIEW

Our interest in experimental combined therapy began about ten years ago at a time when no one could surely foresee whether chemotherapy of pneumococcus pneumonia would entirely replace antiserum therapy. In a paper published in the *Journal of Immunology* in May, 1939,[1] the writer, in collaboration with W. A. Jamieson, reported on single and combined experimental therapy of pneumococcus intraperitoneal rat infections using a broadly acting rabbit antiserum and sulfapyridine. The antiserum was prepared through treatment of rabbits intensively with an R variant of the original Neufeld type I pneumococcus. While this antiserum was of low type specific protective power, its action appeared to be spread widely across many types of pneumococci, and simplicity of combined therapy motivated its selection for our experiments.

This early work on combined therapy, involving use of antiserum on the one hand and sulfonamide on the other hand, and dealing with experimental infections produced by pneumococcus types I, II, III, V, VII, VIII, and XIV may be summarized as follows: The antiserum alone had considerable curative action. The same was true of sulfapyridine alone. Combination therapy of both antiserum and sulfapyridine together appeared to have an additive curative action. We could not prove at that time that these two agents had a synergistic curative action.

In later studies of combined therapy (i. e.,

* Presented at the Second Inter-American Congress on Brucellosis, Buenos Aires, Argentina, November 23, 1948. Submitted for publication January 12, 1949.

penicillin plus sulfonamide), we experimented with sulfonamide-fast pneumococci, and it was not known then when races of sulfonamide-fast bacteria might be encountered in natural disease. At this time (seven years ago) penicillin in crude form was under study in this laboratory. It was natural to try penicillin experimentally for the first time in sulfonamide-fast pneumococcus infections, and the cures obtained were entirely successful. Results of this work were published in the *Proceedings of the Society for Experimental Biology and Medicine*, 1942, volume 49, pages 387 to 389[4] and verified very quickly. Incidentally, in this early work we used penicillin orally in experimental mice infected with sulfonamide-fast pneumococci, and although the experiments were successful, and mice on 10,000 MLD of culture survived, we were assured many times during the next few years that penicillin could not withstand action of gastric juice, acidity, etc.

On the basis of experiments with (a) combined therapy as related above and utilizing anti-serum and sulfonamide, and the showing that biological defense and anti-microbial drug action could fortify each other and possibly act synergistically, and (b) successfully dealing with infections specifically fast to one drug (i. e., sulfonamide) by subsequent use of another and anti-microbial drug (i. e., penicillin) having probably a much different mechanism of action, we were impressed by the rationale of use of streptomycin and sulfadiazine in brucellosis by Pulaski and Amspacher,[5] Spink and associates, [6, 7, 8] and Harris and Jett.[9] Similar combined use in influenza bacillus meningitis could also be mentioned, and in this instance antiserum, streptomycin, and sulfadiazine have been used in combined therapy. Whether the microbe is resistant specifically to the agent, or in other words fast, or whether he is protected by being intracellular, may both add up to about the same thing so far as the host or patient is concerned, i. e., cure is not obtained. If, on the other hand, the infecting microbe is combatted anteriorly by one drug, and laterally as it were, by a second drug, he may be so maltreated that he cannot find a safer site, or metamorphose into a fast condition.

EXPERIMENTS WITH BACILLUS BRONCHISEPTICUS (BRUCELLA BRONCHISEPTICA)

In order to study the combined treatment comprising use of streptomycin and sulfadiazine a little further for verification of its different merits, we have chosen not to attempt to duplicate the experimental results Spink and collaborators have had in embryonated eggs infected with Brucella, but have utilized an experimental Bacillus bronchisepticus (Brucella bronchiseptica) infection in white mice. We wished to deal with a gram negative organism of considerable normal resistance to drugs, and of moderate virulence in an intact animal, and furthermore we wished to give the infecting bacteria and therapy by different routes, and utilize a test in which rapid results would be evident. Use of Bacillus bronchisepticus, the mucin coating technique, and intraperitoneal infection of mice provided an easy method for observing relative life-saving effect of single and combined therapy utilizing streptomycin and sulfadiazine given subcutaneously and orally respectively.

Laboratory strains of Bacillus bronchisepticus which were available to us were of insufficient virulence for mice. A fresh strain was isolated from rabbits, and this was of adequate virulence. The results of separate and combined therapy in initial experiments with streptomycin and sulfadiazine in mice infected with decimal dilutions of 24-hour culture Bacillus bronchisepticus administered intraperitoneally by the mucin coating technique may be described as follows: Streptomycin was given subcutaneously and sulfadiazine was given orally, i. e., both drugs being given by routes different from the infecting dose of bacteria.

It was observed that the approximate LD_{50} of test culture for control mice was a little less than 10^{-5} cc. Mice intended for drug treatment and which got 10^{-2} cc. and 10^{-3} cc. of culture, therefore, received approximately 1000 and 100 LD_{50} of culture respectively. In these tests sulfadiazine treatment appeared better than streptomycin treatment, and combined treatment with both drugs was better than either alone. The combined treatment seemed to be additive rather than synergistic, however. This experiment utilized 100 white mice.

A second set of experiments was done with the initial difference that the virulence of the test culture was less, i. e., having an LD_{50} of about $10^{-3.5}$ cc. instead of about 10^{-5} cc. In these experiments sulfadiazine again appeared a little better than streptomycin, and combined therapy with both drugs appeared better than therapy with either drug alone. Combined therapy in these tests may have been synergistic instead of merely additive. This has been the case in other similar experiments not recorded here, and so-called synergistic results are more apt to show up when the number of LD_{50} in the infecting doses of culture are not excessive. The more overwhelming the infection, the more difficult is the combat between drug and microbe, and leisure effects of drug may not have time to register themselves before it is too late. This experiment utilized 100 white mice.

A third set of experiments was then done, with the difference that full doses of drugs in single therapy were compared with half-size

doses of drugs in combined therapy. The results indicated that half-size doses of drugs in combined therapy are better than full-size doses in single drug therapy. This would tend to show some synergistic effect, i. e., the results were somewhat better than would be expected from simple additive effects. This third experiment utilized 70 white mice.

The above three sets of experiments have been selected from many which have been done. Additive curative effects have most always been obtained. These additive curative results may now and then increase in excellence to synergistic results.

DISCUSSION

Prior interest in combined therapy involving use of antiserum and sulfonamide drug, and effective subsititution of one chemotherapeutic drug for another (having probably a much different mechanism of action) in experiments with certain chemotherapeutically fast bacteria has led us to experiment further in the laboratory with combined streptomycin and sulfadiazine chemotherapy. Our use of Bacillus bronchisepticus (sometimes referred to as Brucella bronchiseptica) permitted utilization of experimental infections of intact mice through the mucin coating technique, and made it possible to infect by one route, i. e., intraperitoneally, and treat chemotherapeutically by other routes, i. e., subcutaneously and orally. This organism proved moderately virulent for mice under such conditions, and one could experiment with infections comprising 10 up to 1000 LD_{50} of culture.

The mucin coating technique (i. e., the mixing of mucin with the infecting bacteria) is beset with one main difficulty, i. e., the mucin is somewhat toxic, and mice treated intraperitoneally with this substance suffer an immediate peritonitis. The mice appear in distress, and have their hair ruffed up and refuse to move about, and drink very little water. Toleration of chemotherapeutic drugs in such experiments is less than the usual instances when bacteria are administered in saline or broth.

The experiments herewith reported, however, are in line with more direct combined chemotherapeutic experiments conducted by Spink and associates in embryonated eggs infected with Brucella, and trials of combined chemotherapy in human Brucellosis. Combined therapy is almost always additive, and sometimes synergistic in effectiveness. Laboratory and clinical evidence, now pretty conclusive, indicates that bacteria combatted with two or more antimicrobial drugs of different modes of action are much less able to metamorphose into a fast condition than would be the case in single drug chemotherapy.

For a recent review of the field of combined chemotherapy, the reader is referred to a report of this year by Kolmer and Rule.[10]

CONCLUSIONS

1. Combined streptomycin plus sulfadiazine therapy in mice infected with Brucella bronchisepticus indicates nearly always at least an additive favorable effect of one drug plus the other.

2. If infections are not excessively overwhelming, the additive effect seems to increase to a synergistic effect.

3. Pending discovery of more powerful specific chemotherapeutic agents, the experiments described here, insofar as they go, verify the general academic merits claimed for combined chemotherapy in brucellosis by Spink and others.

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Hypoglycemia

Conn classified the hypoglycemias as follows:

1. Organic—recognizable organic lesion.
   a. Hyperinsulinism.
      1. Pancreatic island cell carcinoma.
      2. Pancreatic island cell adenoma.
      3. Generalized hypertrophy or hyperplasia of islands of Langerhans (many cases will not show either in the microscopic sections.)
   b. Hepatic disease.
   c. Pituitary hypofunction.
   d. Adrenal hypofunction.
   e. Central nervous system (lesions of brain and brain stem, said to interfere with the nervous control of blood sugar).

2. Functional—no recognizable anatomic lesion.
   a. Hyperinsulinism (autonomic nervous system imbalance?).
   b. Renal glycosuria (severe degrees of low renal threshhold for dextrose).
   c. Severe continuous muscular work.
   d. Pregnancy and lactation.—Landry & Burns, Conn. State Med. Jour., Vol. XIII, No. 8, Aug., 1949.

Varicosities of the Spinal Canal Veins in the Lumbar Region Simulating Disc Herniations

ARNOLD D. PIATT, M. D.

LOW back pain with neurologic signs in the lower extremities is most often attributed to herniation of the intervertebral disc or the component nucleus pulposus. Infrequently other pathologic entities, exclusive of true tumors, will produce the same clinical syndrome. Varicosities of the spinal canal veins involving the epidural and pial vessels, producing symptoms indistinguishable from those caused by disc herniation, are usually diagnosed on surgical intervention. The preoperative diagnosis of disc pathology is generally made after clinical and myelographic study with radiopaque material and on subsequent laminectomy, no evidence of herniation of the intervertebral disc or hypertrophy of the ligamentum flavum exists. Instead a large single varix or multiple varices may be found, either epidural or in subarachnoid space, producing pressure on the nerve roots with clinical symptoms identical with those of disc herniation.

Available literature contains rather limited information on this subject from the roentgenologic standpoint. Several recent publications[5, 7, 17] in which intervertebral pathologic entities are described make little if any mention about varices of the spinal canal veins. Epstein and Davidoff[8] reported a case with dilatations of the spinal cord veins and the diagnosis made preoperatively. Extensive "negative serpentine shadows" were described as well as the mechanism producing them. Pial varicosities causing clinical symptoms have been found by some men[3, 4, 10, 14] but the roentgen ray features were only briefly discussed. Several writers[3, 15, 18] have mentioned diffuse droplet formation and scattering which is probably due to "trapping" of the dye in the tortuous furrows. Ramirez[16] noted in his case a double intrusional defect with a diminution in density of the lipiodol column at the site of the lesion in the lumbar region. He offered the statement that quite often negative findings with opaque material occur and that the clinical symptoms instigated surgical investigation. Blockage of the contrast media was another finding by some[15, 18] with the roentgenographic appearance indicative of a tumor process. The mass-like formation of the varices was responsible for the obstructive picture. In another article, Epstein[8] submitted three cases all with the preoperative diagnoses of herniations of the intervertebral disc and also mentioned "channel-like radiolucent shadows" which are produced by pial vein varicosities. One of his cases seems to depict an irregular intrusional defect at the level of an intervertebral space and the density of the opaque column at this level did not appear of uniform quality which suggests the possibility of varix formation.

Globus and Doshay[10] are of the opinion that pial varicosities are the result of an obstruction at a higher level, from one cause or another, impeding the return flow of venous blood in the spinal veins, and cite Kaydi.[14] They also refer to Benda[2] who classified dilatations of the spinal veins into three forms: phlebectasias, varicosities, and venous angiomata. Varicosities are described as diffuse, irregular dilatations with circumscribed, ampullar or sac-like formations and are a more advanced stage than the first form. Varices of the pial vessels seem to predominate on the dorsal surface of the cord often having a plexiform or cirsoid formation, according to Kaydi,[14] Globus and Doshay,[10] and present a bluish appearance when seen through the dura. Greenwood[12] states that most of the spinal epidural varices are located anteriorly and, most frequently, the larger ones.

A brief anatomical resumé of the spinal canal veins might be of interest at this point in order to more fully comprehend the roentgenologic aspects. The venous circulation of the spinal canal and cord is quite profuse and extensive. According to investigators,[1, 6, 11] the thin-walled spinal canal veins, somewhat embryonic in character, are mainly without valves and are divided into main groups. (1) The venous plexuses in the canal between the dura and the vertebrae are called the intraspinal veins or often referred to as the epidural veins. One group of large

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veins, located on the posterior aspect of the bodies of the vertebrae, are longitudinal in direction and situated on either side of the posterior longitudinal ligament. These have been termed the anterior internal plexuses. Similar veins exist in the posterior segment of the canal, anterior to the arches of the vertebrae and the ligamenta flava, and are called the posterior internal plexuses. The vertical vessels are connected by venous rings located at the levels of the bodies of the vertebrae. Transverse branches join the anterior longitudinal veins beneath the posterior longitudinal ligament and into these the basivertebral veins from the bodies empty. (2) The pial veins or veins of the pia mater consist of two longitudinal veins in the midline, one on the anterior aspect of the cord and the other on the posterior surface, opposite the median fissures. There are also four vertical vessels situated laterally behind the nerve roots and terminate in the intervertebral veins. The intervertebral veins, draining the internal vertebral plexuses as well as the external plexuses and the veins of the spinal cord, follow the spinal nerves through the intervertebral foramina.

ROENTGENOLOGIC FEATURES

On myelographic examination a single large varix of the epidural veins producing an intrusional defect on the column of dye may not be differentiated from a disc excepting when the level of the defect is observed other than at the plane of the intervertebral space. One of our cases presented smooth rounded notchings at intervertebral space levels leading to an erroneous diagnosis of disc protrusions. (See Figures 2 and 3.) A fairly lax dura must exist to allow the imprint of the epidural varix on the contrast media. Multiple varicosities of the intraspinal veins may produce serrated defects on the margins of the column of radiopaque material with little if any relation to the intervertebral spaces. The tendency for inconsistency of the defects, due to the compressibility of the varices, is another indication of their existence. One would then suspect the true character of the pathologic process rather than the presence of several discs. Pial varicosities may produce a pathognomonic picture because of their location in relation to the subarachnoid space. A single varix may create a defect pattern simulating that of a disc, although again it might be at a level other than the intervertebral space. When a single furrow-like radioparency in the midline is seen, one should strongly consider a varix arising from a pial vein in one of the median fissures. Multiple varices of the pial vessels would tend to produce irregular serpentine indentations on the contrast media and as such are indicative of the entity present. Fluoroscopically, one might see persistent, sinuous "channel-like" defects which closely resembles the picture of varices of the esophagus. Occasionally the column of dye may break up into rounded globules and this formation may occur normally in the canal during an examination. "Trapping" of the contrast material in tortuous varicose furrows presents a slightly different picture than that observed in the separation into globules mentioned above. The opaque mottling tends to have an irregular clumped appearance with no definite pattern. A large collection of varicosities might even create an obstructive phenomenon simulating the appearance of a tumor.

CASE REPORT

W. S., colored male, aged 40, for the past three years complained of low back pain and aching with the pain radiating down his right leg. The patient sustained an injury while lifting a heavy mold, losing his balance and twisting his back in his fall to the ground. At that time he had a sudden severe sharp pain in his lower

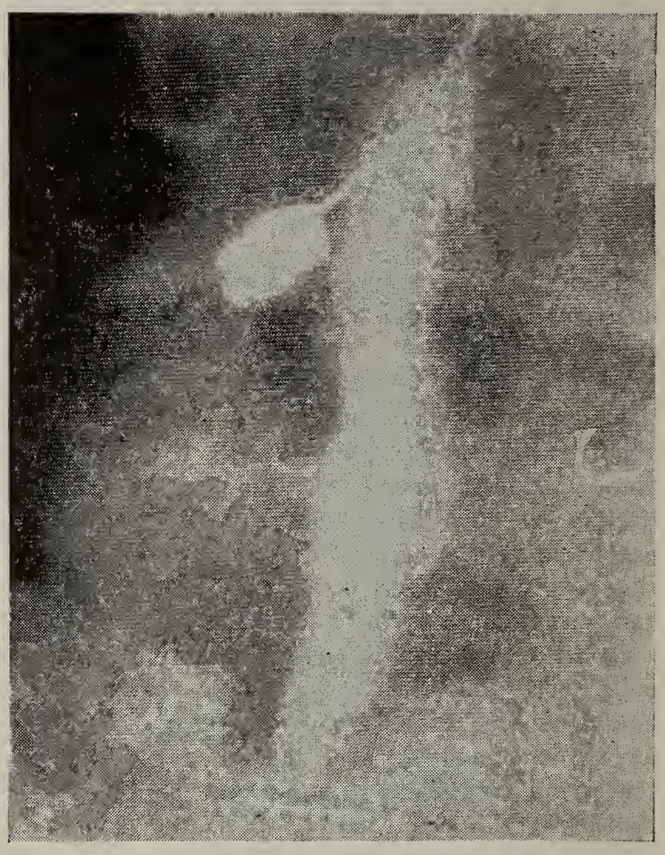
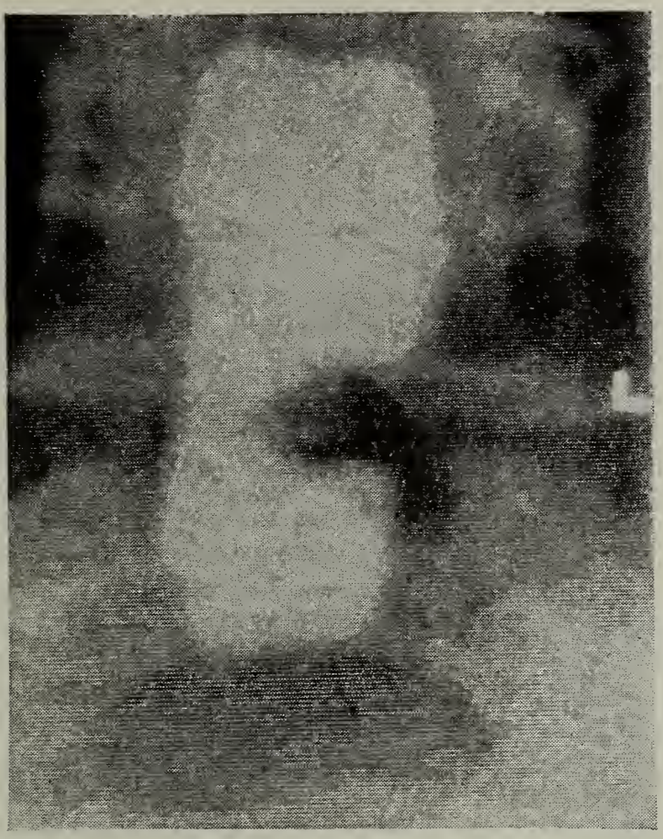


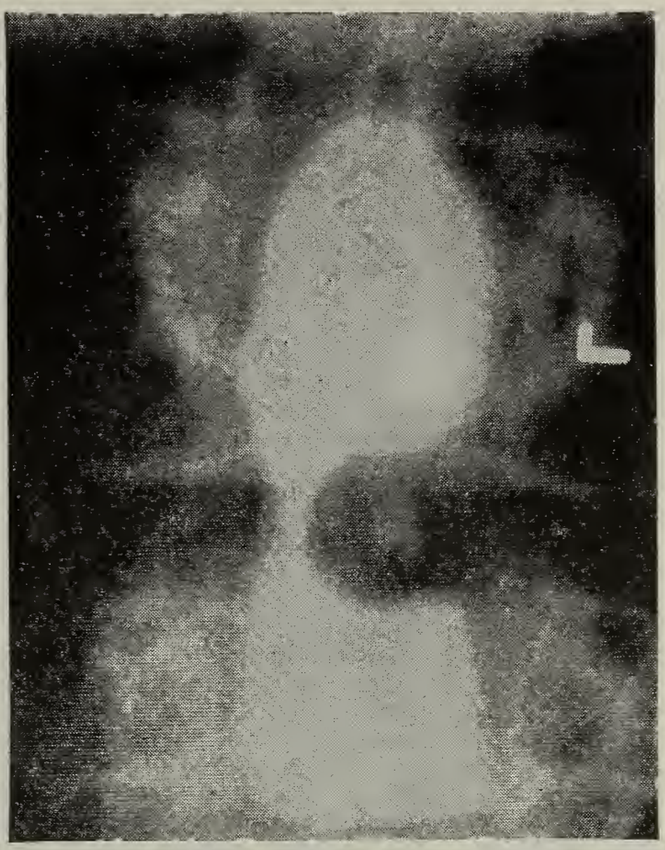
Figure 1. Note the irregular margins of the column of dye with a "trapped" fleck on the left.

lumbar region. A short period of partial total disability occurred due to the increase in symptoms and progressive discomfort. Various orthopedic measures were instituted over the period of three years consisting of a back brace, hospitalization and traction, and injection of the sacroiliac joints. Temporary relief was accomplished with traction and the back brace did to some degree diminish his discomfort.

Three previous X-ray examinations within the past six months showed only mild osteoarthritic sharpenings at the anterior margins of the bodies of the fourth and fifth lumbar vertebrae and a spina bifida occulta of the first sacral segment.

Clinical consultation (Dr. J. Wilson) on July





Figures 2 and 3. The smooth finger-print indentations at the levels of intervertebral spaces were interpreted as herniations of the discs between L3, L4 and L5.

23, 1948, revealed a well-developed and well-nourished colored male with a list to the right in the standing position. Straight leg tests were positive on the right leg with a diminution of reflexes on the right side. On the left, the muscles were spastic when standing but relaxed when recumbent. A myelographic study of the lower lumbar region was recommended to rule out the possibility of herniation or rupture of the intervertebral disc.

On August 17, 1948, a spinal tap was performed and approximately six cc. of spinal fluid was removed with no apparent increase in the cerebrospinal fluid pressure. Three cc. of pantopaque was instilled into the spinal canal under fluoroscopy and the patient examined fluoroscopically in several positions (lateral, prone, semi-upright and Trendelenburg) with the dye maintained in the lumbar and sacral segments. It was noted that an irregularity of the column of dye prevailed between the fourth and fifth lumbar on the right and left sides. The axillary sheaths were also irregularly placed in the region of the fourth and fifth lumbar vertebrae and the one in the region of the fourth on the left side seemed higher than the corresponding one on the opposite side. There seemed to be a filling defect on the left side which partially obliterated and displaced the pouch of the fourth and a small globule of dye was observed apparently "trapped" from the main body of the contrast media. Spot films were made confirming and corroborating the fluoroscopic images. (See Figure 1.) A tentative diagnosis was submitted of inflammatory changes or varices as the findings were not consistent with herniation of the intervertebral disc or tumor. The laboratory results of the cerebrospinal fluid showed the total protein content to be 34 mg. per 100 cc. and the Kahn was negative.

One month later, the patient was operated on (Dr. J. Wilson) and the following is a brief summary of the findings. An incision was made from the sacrum to the third lumbar and these were exposed periosteally. A great deal of hemorrhage was encountered and a number of varicose veins were found along the retrospinal muscles. A punch laminectomy was done between the third, fourth and fifth lumbar vertebrae and a mass of varicose veins was found encroaching on the nerve roots. The nerve roots were pulled aside and the varicose veins were segregated and destroyed by cautery. No evidence of herniation of the intervertebral discs at these levels could be seen nor was there any hypertrophy of the ligamenta flava. The dura was not opened and there did not seem to be any varicosities of the pial vessels.

Three weeks following the operation, the patient was discharged from the hospital with the wound healed and relieved of his low back pain.

CASE REPORT

L. P., white female, aged 40, for approximately twenty-three years has had intermittent bouts of severe low back pain with inability to move the lower extremities. The onset dates from a pushing injury to the back while playing volley ball. In 1946, following one episode of severe pain, traction was applied to both legs with some relief. Later, the patient had her coccyx removed when she had a recurrence of her symptoms. Another bout of acute lumbar back pain in June, 1948, necessitated sedation with narcotics and there seemed to be but little relief obtained even by this method. Traction was again instituted to both legs for one week and this time there was complete disappearance of her pain. Three days later, the symptoms recurred and the pain was referred down both legs on

exertion, coughing or sneezing. At this time, no reflex or sensory changes were found in the lower extremities.

On July 1, 1948, the patient was hospitalized and a posterior plaster shell cast was applied during her stay and then she was dismissed from the hospital. One week later, the patient was readmitted and X-rays taken of her lumbar spine. The radiographic findings revealed a narrowing of the intervertebral space between the fifth lumbar and first sacral segments and a tendency for the bodies of fifth lumbar and first sacral vertebrae to impinge on each other posteriorly. A spina bifida occulta of the first sacral segment was also seen.

A few days afterwards, a myelographic study of the lumbosacral spine with contrast media was performed. The cerebrospinal fluid on lumbar puncture did not show any increase in pressure. Sufficient fluid was removed to allow laboratory procedures. The total protein was 28 mg. per 100 cc. with a trace of albumen and globulin. The Wassermann was negative.

Three cc. of pantopaque was instilled into the subarachnoid space under fluoroscopy and the patient examined fluoroscopically and by X-ray spot films in several positions (prone, semi-upright, lateral and Trendelenburg). Intrusional defects were found at the disc levels between the third, fourth and fifth lumbar vertebrae on the left side. The axillary pouches were obliterated on the left at these same segments. The smooth notching type of defects were considered to be disc protrusions. (See Figures 2 and 3.)

Surgery was instigated (Dr. J. Wilson) several days later and a summary of the findings are submitted. After an incision from the second lumbar to the second sacral was accomplished, the laminae were exposed subperiosteally. A punch laminectomy on the left side between the third and fourth lumbar vertebrae was made and on pulling the nerve root medially, large veins were encountered and some ruptured causing severe hemorrhage which was controlled by cottonoid packs. The canal was explored and no ruptured disc was found. The operative field was enlarged by further punch laminectomies between L4, L5, and S1. Large tortuous veins were observed at these sites, however, no disc herniations were discovered. A definite narrowing of the intervertebral space existed between L5 and S1 and the contemplated fusion indicated was abandoned because of the amount of hemorrhage and the stage of shock of the patient. Transfusion was necessary and the patient was given whole blood and plasma. The postoperative course was uneventful and the patient was discharged in ten days with some improvement in her symptoms although not entirely free of pain.

Subsequent follow-up after a period of two months disclosed the patient to have a return of her symptoms with pain over the operative scar. Considerable muscle spasm was present and the pain now radiated to the occipital region of the skull. Again she was placed in a body cast for a month. In October, 1948, a spinal fusion was endeavored (Dr. J. Wilson) but a large postoperative meningocele was found in the region of L5 and S1. This was repaired and the fusion was not performed. The postoperative course was extremely stormy with intractable pain in the legs and back. After several days, the discomfort subsided and the patient was discharged markedly improved.

SUMMARY

In summary, the possibility of varicosities of the spinal canal veins should be kept in mind when a tentative roentgenographic diagnosis of herniation of the intervertebral disc has been offered. Other conditions such as tumors and diffuse disseminated arachnoiditis closely manifest similar findings. No attempt is made to differentiate between these and varices. Several diagnostic points have been presented to aid in the differentiation between disc herniation and varicosities. Two case reports are submitted.

Author's Note: Appreciation is extended to Drs. Raymond S. Lord and John C. Drake for permission to report these cases.

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Low Back Pain

Symptoms from postural strain usually arise from fatigue which results either from occupational strain or systemic depreciation. The symptoms are indefinite. The pain is diffuse and indefinitely referred. Localized tenderness and muscle spasm are not accurately described or found. The patient is likely to have a temperature of 99 degrees or above.—E. D. McBride, Rocky Mt. Med. Jour., Vol. 46, No. 8, Aug., 1949.

Need for Hospitals to Tie in With Rehabilitation Services in Their Work with the Physically Handicapped

EUGENE J. TAYLOR

TO THE physician, the term "rehabilitation" has long connoted "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." In general usage, however, the term itself, during the past few years has lost much of its significance, for it has been used to describe everything from correctional programs in modern penal institutions, to the social and economic rebuilding of war devastated countries. With the developing emphasis being placed on the processes of restoring handicapped workers, a new term has arisen which describes such processes more aptly and with more virility. That term is "the third phase of medical care."

The modern concept of this third phase of medicine, which takes the patient from the bed to the job, springs both directly and indirectly from the war. The rehabilitation programs of the military services and the veterans Administration demonstrated that planned, integrated programs of convalescent care stressing activity as an adjunct to definitive treatment could reduce the period of hospitalization, offset the deconditioning phenomena of bed rest, and prevent the harmful psychological sequelae which often result from extended hospitalization. The techniques of physical rehabilitation and retraining for the severely handicapped developed by the military services also have profound implications for the even larger number of our civilian population who are disabled.

HIRING THE HANDICAPPED

Indirectly, the war also created interest in the third phase of medical care, for due to the wartime manpower shortage, many disabled civilians for the first time had an opportunity to take their place on production lines and demonstrate that, with proper selective placement, they were efficient, reliable, safe employees. Prior to the war, many employers refused to hire handicapped workers on the grounds that they were more accident prone than the able-bodied. The industrial accident rate of 87 of the great industrial plants in America, each having from 50 to 12,000 handicapped employees, has proved that concept fallacious. Studies of their experience show that 56 percent found the accident rate of the handicapped lower than that of the able-bodied; 42 percent found that rate the same as for the able-bodied; and only 2 percent found it to be higher.

The Bureau of Labor Statistics of the Department of Labor has recently completed an exhaustive study of the work performance of 11,000 impaired and 18,000 matched unimpaired workers subjected to the same job incentives and exposed to the same job hazards.[1] The data taken from industry's own records show conclusively that the physically impaired person is not necessarily a handicapped worker if given reasonable job placement consideration. The two groups had identical frequency rates of nondisabling injuries, and the average rates of absenteeism showed no significant difference. The impaired workers, however, produced at a slightly better rate, and had relatively fewer disabling work injuries than did unimpaired workers on the same jobs. No matter how different these physically impaired workers may have been in other respects, on the job they were just another group of workers able to meet their unimpaired fellow workers on an equal competitive footing.

It is well recognized that the compensatory laws of nature make adjustments in the abilities of the handicapped worker. We know that the loss of one sense leads to the sharpening of the other senses; that men with no legs develop more capable hands; that men without vision develop their sense of touch to the highest degree. Such compensatory abilities are not automatic; they come only through experience and training. To be of maximum vocational value, their development must be under skilled guidance.

ADVANCES IN REHABILITATION

Immediately following World War I, as today, there was a developing interest in increasing rehabilitation opportunities for the disabled. Unfortunately, this interest died in many quarters in the years between the wars. From it, however, did come some pioneer institutions and some

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An address given before the Ohio Council for the Handicapped at the Ohio Welfare Conference, November 16, 1948.

needed legislation such as the Federal Vocational Rehabilitation Act of 1920.[2] The failure of the movement to gain sufficient stature to become an accepted part of medicine can be attributed to the fact that it was restricted largely to guidance, trade training and the purely vocational aspects of rehabilitation. Few provisions were made for physical restoration or reducing the physical disabilities of the trainees. When the physical condition became static, a program of vocational rehabilitation was planned "training around" the disability rather than attempting to reduce or eliminate it through medical procedures. In many instances, a comparatively large expenditure of time and money was necessary for vocational rehabilitation when, by the expenditure of a few weeks and a modest sum, the physical limitations could have been substantially reduced with an automatic increase in employment potentials. Such restrictions made it impossible for the state vocational rehabilitation programs operating under the Federal Office of Vocational Rehabilitation to give adequate service to their clients. Such failure is shown by the fact that, until the basic philosophy of this program was changed by the Barden LaFollette Act of 1943, in 23 years only 210,000 persons were rehabilitated although over a million persons were in need of such aid at any given time during that period.

One of the most significant advances made in rehabilitation during the war and the immediate postwar period has been the increased recognition given to medical rehabilitation as an integral part of medical care. Just as satisfactory job placement is the capstone of any successful program of services to the handicapped, medical rehabilitation, starting at the earliest possible moment following acute illness or injury, is the foundation, since all subsequent rehabilitation processes are built upon the residual disability which medical care cannot eliminate.

Unfortunately, until the advent of World War II, medical care, psychologic problems, and vocational rehabilitation were too frequently considered as separate and distinct processes having little relationship to each other. That they are interdependent and inseparable has been demonstrated by the successful programs in military and veterans' hospitals, and has been recognized in civilian rehabilitation by the Barden-LaFollette Amendment, which expanded the Federal-State vocational rehabilitation programs, to include physical restoration, psychiatric services, medical care, as well as vocational guidance and training.

EXTENT OF THE PROBLEM

The lack of a systematic approach requiring the reporting of cases of physical disability to a central agency, together with varying subjective interpretations of "what constitutes a handicap," makes it difficult to stake out the boundaries of the field of rehabilitation and services to the handicapped in any quantitative fashion.

Although a census of such conditions has been proposed on several occasions (legislation calling for an exhaustive census of the physically handicapped was introduced in Congress by Senator Johnson of Colorado on March 15, 1948),[3] there has never been a complete survey of the extent of disability in the United States. The most comprehensive source of information at present is the National Health Survey, conducted by the U. S. Public Health Service in 1935-36.[4] In this survey, 800,000 families in 83 cities and 23 rural areas of 19 states were studied. The reliability of this study has been demonstrated in other extensive surveys on the extent of chronic disease and crippling conditions, and although results are not strictly comparable, due to different methods of enumeration, they bear out the fact that the National Health Survey is probably the best source available for such statistics, although later studies indicate that its results are conservative.

Although the focus of attention has been centered on the disabled veteran, the extent of disability among our civilian population is far greater.[5] There were 19,000 amputations during World War II, but over 120,000 major amputations during this same period among our civilian population. Approximately 1,500 men were blinded while in military service during the last war, but 60,000 civilians lost their sight during this period. Some 265,000 men were permanently disabled as a result of combat injuries during the war, but 1,250,000 civilians were permanently disabled by disease and accidents in the corresponding four years.

There are some 23,000,000 persons in the United States handicapped to some extent by disease, accidents, maladjustment, or war. One-third of all draftees were rejected as unfit, and more than 1,000,000 had to be discharged shortly after induction.[6] In 1946, 10,400,000 persons suffered disabling accidents, and of these, 370,000 were disabled permanently.[7] It is estimated that there are over 7,000,000 persons in the United States disabled by diseases of the heart and arteries, 6,850,000 from rheumatism and arthritis, and 2,600,000 from orthopedic conditions.

These are the numbers, but they cannot tell the story of pain, anxiety, suffering, and all of the vital secondary problems that disease and disability leave in their wake. Aside from pain and tearing personal and family anguish, the economic costs of disease and disability are staggering.

TOLL OF CHRONIC DISEASE

Today, as medical science moves forward in the prevention and cure of infectious disease,

chronic illness has become the nation's primary medical problem. In 1900, seven chronic diseases (cancer, diabetes, intracranial lesions of vascular origin, diseases of the heart, diseases of the arteries, cirrhosis of the liver, and acute and chronic nephritis) were responsible for 25.7 per cent of all deaths in New York State.[8] Between 1900 and 1940, a period in which the population of New York State increased by 85 per cent and the total number of deaths increased by only 13 per cent, the number of deaths from this group of chronic diseases increased by 200 per cent, and now includes over two-thirds of all deaths in the State.

Whereas diabetes ranked twenty-seventh and arteriosclerosis thirty-fourth as causes of death in 1900, they were eighth and tenth in 1944.[9] Added to this is the tremendous long-term toll of chronic illness and disability. Acute infectious disease usually results in rapid recovery or death, but chronic illness may linger for years. Its social and economic costs cannot be measured by mortality tables alone.

One of the principal causes of the increasing prevalence of chronic disease has been the great advances in medical and surgical care which have prevented death and produced an aging population. Two thousand years ago, the average length of life was twenty-five years; at the turn of the century, it was forty-nine; today, it is sixty-six.[10] In 1900, one person in 25 was sixty-five years of age or older; it is estimated that in 1980, the ratio will be one in ten. The chances are now two out of three that a young man now starting his working life at the age of eighteen will live to his retirement age of sixty-five. A forty-five-year-old man today has 70 in 100 chances of reaching the age of sixty-five, and the chances for a fifty-five-year-old man are 78 in 100. White men now at the age of sixty-five can expect to live an additional twelve and one-half years on the average, and white women an average of fourteen and one-quarter years.

As people become older, their medical needs change, and they demand more medical service. In 1940, the 26.5 per cent of the nation's population over forty-five required over half the nation's medical services. By 1980, it is expected that the number of persons over 45 will constitute nearly half of the population.

The incidence of chronic disease is definitely related to economic status. It develops most frequently among families of low income, and when it strikes, results in further reduced income and depletion of financial reserves. In the National Health Survey of 1936, chronic illness was found to exist nearly twice as much among persons on relief as those earning $3,000 a year and over. A more recent study in Illinois showed that 23 per cent of all public assistance recipients were chronic invalids.[11] In Connecticut, the percentage was 20,[12] and in New Jersey, 38 per cent of those receiving old age assistance are chronically ill.[13]

Although chronic diseases is more prevalent in older persons, authorities state that 16 per cent of all persons with known chronic disease are under twenty-five years of age. The Yale study found the percentage to be 33.

REHABILITATION IN THE VETERANS ADMINISTRATION

There was, at the war's end, some skepticism of the value of medical rehabilitation in the Veterans Administration hospitals for veterans of World War I and those of the Regular Army who suffered from chronic illness and long-standing disabilities. Some physicians feared that young veterans of World War II would soon lose ambition, initiative and a desire for personal independence through association with older veterans who had developed "hospitalitis" as a result of boredom, frustration and hopelessness. In the veterans hospitals where comprehensive, dynamic rehabilitation programs are now in operation, the results have been not only revealing but encouraging.

Typical of the results obtained in the Physical Medicine Rehabilitation program of the Veterans Administration is a study of 130 chronic neurologic patients in one hospital, all but two of whom were World War I veterans, and many of whom had not been out of bed in ten years. After nine months of physical medicine rehabilitation, 25 had left the hospital and were employed; 40 others had been discharged to their homes capable of light work, and, of those remaining, 30 were ambulatory and undergoing advanced rehabilitation and 25 were capable of some self-care. All but 10 of the group had shown worth-while permanent improvement. With a five-year expectancy of these patients, and a per patient day hospitalization cost of over $12, rehabilitation of this one group has saved the government, and eventually the taxpayer, over $1,125,000. It would seem logical that a similar program for the civilian chronically ill would result in comparative savings.

In another study at the Veterans Administration Hospital at Manhattan Beach in Brooklyn, through rehabilitation, 74 of a group of 126 patients suffering from such diseases as arthritis, multiple sclerosis, paralysis and Buerger's, Parkinson's and heart disease, have been discharged from the hospital and are now at home taking care of themselves.[14] All but 13 of the original 126 patients have recovered all or part of their ability for self-care. At the beginning of this program, 83 of these veterans were "completely hopeless," but 49 in that group have been rehabilitated to the point of complete

independence, and the remainder are capable of self-care.

THE ECONOMIC ASPECTS

The experience of the Federal Office of Vocational Rehabilitation has also shown how rehabilitation pays off economically. During 1944, 43,997 persons underwent rehabilitation under the joint Federal-State vocational rehabilitation programs.[15] Of this group, 22 had never held jobs, and 90 per cent were not employed at the time they started their rehabilitation. Their average annual wage after rehabilitation was $1,768, as compared with $148 before. The cost of their rehabilitation was but $293 per case, a single rather than annually recurring expenditure.

These spectacular results are not attributable to the short labor market of the war. The approximately 44,000 persons rehabilitated in 1947 are now earning at a rate exceeding $70,000,000 a year, and this year they will pay over $5,000,000 back to the Federal Government in Federal income taxes alone. The average rehabilitant was 31 years of age. If he works during 85 per cent of his life expectancy, he will pay $10 in Federal income taxes for each dollar the Federal Government has invested in his rehabilitation.[16]

Prior to rehabilitation, many of these persons now wholly or partially independent, were on local relief rolls at an annual cost of from $300 to $600 per case. In a study of such cases made in 1947 in Michigan, the relief costs of 400 cases were approximately $250,000,000 per year. This same group, after rehabilitation, had been removed from the relief rolls, for they were earning more than $600,000 a year. In another state, the program gave rehabilitation services to a young man of 21 who was drawing $30 a month, or $360 a year in aid to the blind. He was trained to operate a vending stand, and at the end of his first year on the job, paid $250 in income taxes.

REHABILITATION IN THE GENERAL HOSPITAL

Although it would seem logical that medical rehabilitation would be an important service in every civilian hospital, there has been little or no attempt, until recently, to establish such programs in civilian hospitals. Of the 1,468,714 hospital beds in the United States in 1946, 44 per cent were in general hospitals, but these 641,331 beds cared for over 92 per cent of all patients.[17] Rehabilitation, in varying degrees, has been available in some tuberculosis, mental, and other specialized hospitals, but little provision has been made for dynamic convalescent care and rehabilitation of the over 14,000,000 persons who are patients in general hospitals each year.

The first comprehensive total medical rehabilitation program in any community hospital in this country has recently been inaugurated at Bellevue Hospital in New York. Operated under the professional direction of the Department of Rehabilitation and Physical Medicine of the New York University College of Medicine, the service has bed facilities for 80 patients and offers a program of physical medicine, physical therapy, occupational therapy, corrective physical rehabilitation, social service, corrective speech, psychologic services, vocational guidance, education and planned recreation. It operates as a service department to the other departments of the hospital in much the same manner as the X-ray and laboratory, and treats both inpatients and outpatients on reference from the other services of the hospital.

The rehabilitation service in Bellevue Hospital which will be enlarged to 600 beds when the construction planned is completed, is the first step in a plan by the Department of Hospitals of the City of New York to provide all patients in municipal hospitals of the city with medical rehabilitation services. The extent to which rehabilitation has entered into future planning in New York in both public and private hospitals is shown by a recent report of the Hospital Council of Greater New York, in which it was suggested that 25 per cent of the bed capacity of the city's general hospitals should be allocated for convalescence and rehabilitation.[18] This would mean one such bed for each 1,000 of the city's population.

The interest in extending medical rehabilitation services in general hospitals is not limited to New York City or other large urban areas. The Veterans Administration has recently established such services as major departments with specified bed allocations in all Veterans Administration hospitals. The New York State Health Preparedness Commission has recommended that the State should build or acquire and support a chronic disease hospital center contiguous to a general hospital, in close proximity to a medical school, and staffed and operated by contract with such hospital and medical school in each of five geographic regions of the State.[19] They have also recommended that "rehabilitation services for the disabled and chronically ill be developed as rapidly as possible in selected general hospitals throughout the State by providing the services of trained personnel and by providing funds for the training of needed personnel in this field." Today, throughout the nation, there are some 150 communities which have expressed interest in establishing rehabilitation services either independently or in conjunction with existing hospitals, medical schools, or community agencies.

TRAINING OF PERSONNEL

Facilities per se, however, will be of little help in meeting this tremendous problem without

sufficient trained personnel to operate them. Today, a number of medical schools have recognized the increased need both for giving general practitioners some training in this field and for providing training opportunities for specialized personnel. One of the first medical schools to start such a program is New York University, where a Department of Rehabilitation and Physical Medicine has been in existence as a major department of the college for over a year and a half. Major activities are training, research and patient care, through the use of the teaching facilities of the College of Medicine, the Rehabilitation and Physical Medicine Service of Bellevue Hospital, and the Institute of Rehabilitation and Physical Medicine of the New York University-Bellevue Medical Center.

Undergraduate training during this year consists of a one-hour indoctrination lecture in the first year, ten hours of lecture-demonstrations on the relationship of medical rehabilitation and physical medicine to general medicine in the second year, eight hours of lecture-demonstrations correlating special physical disabilities with anatomy, physiology, and pathology in the third year, and twenty-eight hours of elective classes consisting of lectures, demonstrations, films, and field trips on medical, social, economic, and vocational aspects of rehabilitation, the techniques of physical medicine, and the therapy of the third phase of medical care.

A twelve or twenty-four week course is offered in the postgraduate division, consisting of theoretical and practical training in the uses of the physical modalities, in the evaluation and treatment of physical disabilities by physical, psychosocial and vocational rehabilitation, and in the therapy of the third phase of medicine. Part-time postgraduate courses of variable duration are also given by arrangement.

A MEDICAL RESPONSIBILITY

Few communities in the United States envision or have the need of a community rehabilitation center the size of the new Institute of Rehabilitation and Physical Medicine at New York University or of a general hospital rehabilitation program as large as that of Bellevue Hospital. Their philosophy and administrative pattern, however, can be adapted to even the smallest community. The arthritic, the cardiac, the hemiplegic, the patient with arrested tuberculosis or a severe orthopedic disability—all deserve full medical care from the bed to the job, regardless of where they live. Nor is the opportunity of bringing such care to his patients restricted to the medical specialist. One of the greatest problems in rehabilitation is that of motivation; encouraging, convincing, and demonstrating to the disabled that they can rehabilitate themselves. This motivation, to be most effective, must begin at the earliest possible moment following the accident or crippling illness. The physician who knows something of rehabilitation can start at the time of the accident or onset of the disease to allay the fears of the patient by giving understanding, courage, and hope predicated on an accurate knowledge of what can be done.

If physicians are to meet the needs of their patients, we must know something about rehabilitation and selective placement of the handicapped. They must interpret to their patients the findings of the specialist in words that are simple and understandable. The burden of translating to the patient the nature and extent of his disability falls upon the family doctor. That explanation cannot be in medical terms of the disability alone, but must be in terms of its effect on the vocational, social, economic, family and personal life of the patient.

Medicine must deal with the practical relationship of disability to economic, social and environmental factors. It must realize that the treatment of disease or disability is only a segment of the problem; the primary mission is the treatment of the patient.

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Synovioma: A Case Report with Pulmonary Metastases that Regressed Following Irradiation

R. D. WILLIAMS, M. D., and H. W. MAHAFFEY, M. D.

MALIGNANT tumors of the synovia, first described by Stűer[1] in 1893 and later given the name "synovioma" by Smith[2] in 1927, have frequently been reported during the past two decades. The tumors are characterized by the presence of glandular and villous structures in a connective tissue stroma. Murray, Stout and Pogogeff[3] confirmed the mesothelial nature of these structures by tissue culture studies. More recently Bennett[4] presented the histopathology of 32 cases of synovial sarcoma and discussed the varying interrelationship of the mesothelial and connective tissue elements.

These tumors are notoriously resistant to irradiation and early amputation is the treatment of choice. The following case is presented because of the palliative results obtained by irradiation of the pulmonary metastases.

CASE HISTORY

Case No. 485240, T. M., aged 35, first entered the University Hospital on January 25, 1943, with the complaint of pain in the right foot. The past history revealed that the right great toe had been amputated at another hospital in 1929. The toe bore a tumor that was identified by the pathologist as an angio-endothelioma. In 1941 the patient bruised the dorsum of the right foot. Pain persisted for a year, and a diagnosis of osteomyelitis was made. At operation a sequestrum was removed; subsequently the incision healed without drainage. About a year later he was admitted to University Hospital complaining of severe pain in that region. Examination showed a well-healed amputation stump. The medial aspect of the foot presented a soft red swelling that extended from the medial malleolus to the head of the first metatarsal and laterally beyond the midline of the foot. Aspiration of the lesion yielded only some tissue fluid negative for bacteria by smear and culture. Incision for biopsy revealed a poorly circumscribed tumor mass which on histological examination was identified as a synovioma. Following biopsy the patient was started on a course of irradiation therapy but failed to return after he had received a total of 900 r on the medial and 600 r on the lateral aspects of the right foot. The factors were 200 KV, 25 MA with a filter of 0.65 mm. Cu and 1 mm Al and 50 cm. target skin distance.

The patient was not seen for four and a half years. He returned in September, 1947, complaining of a 36-pound weight loss during the preceding eight months, dyspnea, and a productive cough. Three and a half years previously (March, 1944) the right leg had been amputated below the knee at another hospital. Microscopic examination of the tumor at that time showed a pattern similar to that of the previous biopsy. Physical examination now revealed a tumor in the soft tissue above the right iliac crest measuring 5 by 8 cm. A pleural friction rub, as well as a few fine rales and some decrease in breath sounds, was noted over the right upper lobe. The vital capacity was only 1200 cc. On roentgenographic examination of the chest, both lung fields were studded with nodular densities



Figure 1. Roentgenogram of chest prior to X-ray irradiation.

of various sizes (Figure 1). There was no evidence of metastasis to the ribs, spine or skull.

In a period of thirty days the patient received 2000 r to each of four 15 by 20 cm. ports over the chest. The factors were 250 KV, 15 MA, 20 cm. target skin distance and filters of Thoreus "3" and 1 mm. Al. When he was discharged on the sixteenth hospital day the vital capacity had increased to 4000 cc. Three weeks after completion of the irradiation therapy roentgenograms of the chest showed definite diminution in size and density of the metastatic lesions (Figure 2).

The patient became well enough to resume work for several months. He was readmitted on March 9, 1948, complaining of weakness, cough and diarrhea of three days' duration. The mass above the right iliac crest had increased in size and similar masses had appeared on the posterior surface of the right thigh.

From the Department of Pathology, Ohio State University, Columbus, Ohio. Submitted November 27, 1948.

He was given 50 mg. of diopterin daily for fourteen days but showed no clinical improvement. The pulmonary lesions remained unchanged. During the next two weeks the mass above the right iliac crest was irradiated with 1500 r cross-fired anteriorly and posteriorly over a 20 by 20 cm. field; the factors were the same as before. His general condition had improved when he was discharged on the thirteenth hospital day.

At the time of his final admission on June 25, 1948, the patient was in coma. During the previous two weeks he had suffered clonic convulsions of the right arm and leg and weakness of the muscles of the right side of the face. Despite supportive therapy he expired on the day of admission.

AUTOPSY

At autopsy metastatic tumor nodules were found in the heart, lungs, liver, spleen, left kidney and brain. In the myocardium of the right ventricle were two irregular, partially confluent, 1.5 cm. yellow-pink firm tumor nodules. Beneath the pleura of both lungs were many metastases that measured 1 to 5 cm. in diameter and on section were seen to extend into the pulmonary tissue as spherical masses. Similar tumors were present deeper in the lungs; they were firm, yellow-pink, with fairly well-defined borders, and replaced a large portion of the parenchyma. Many 3 to 4 mm. nodules were present throughout the left kidney, and the lower pole was replaced by a 2.5 cm. metastasis. Beneath the leptomeninges of the left cerebral hemisphere was a 1.5 cm. area of hemorrhage surrounded by neoplastic tissue. Microscopic examination revealed additional small nodules in the spleen as well as the meninges, but there was no involvement of the adrenals, intestinal tract, bones or lymph nodes.

Microscopically these tumors had the typical structure of synovial sarcoma. The two cellular elements that make up the normal synovial membrane, viz., the lining mesothelium and the surrounding connective tissue, were present in their malignant variants. The mesothelial glands were arranged in a pseudoglandular pattern imbedded in a stroma of connective tissue cells

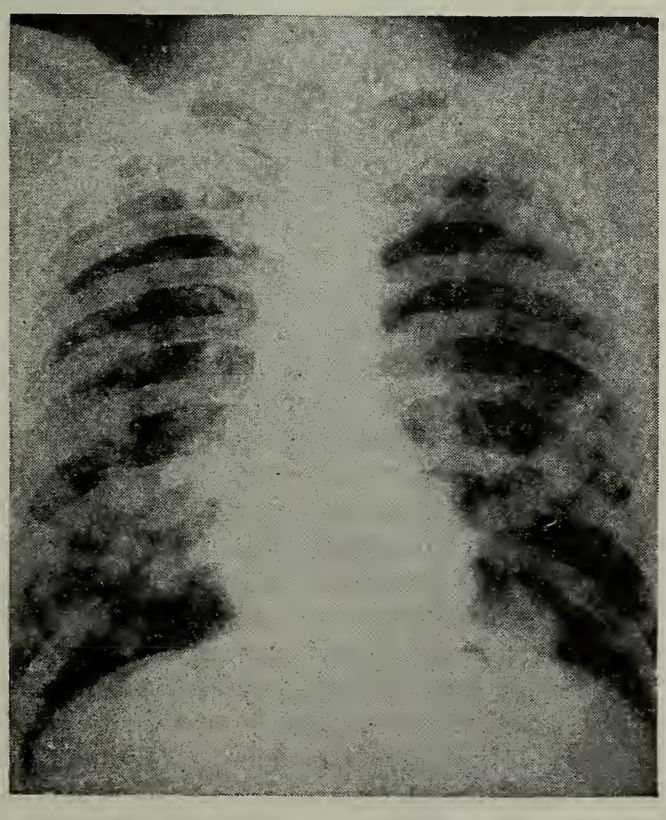


Figure 2. Roentgenogram of chest three weeks after X-ray irradiation.



Figure 3. Photomicrograph of metastatic synovioma of lung. 250X.

(Figure 3). The fibrosarcomatous element was more prominent in the metastatic nodules than in the primary tumor.

COMMENT

The tumor originally diagnosed nineteen years before the patient's death as angio-endothelioma may actually represent the primary lesion in this case. In this respect it is interesting to note that the biopsy obtained fourteen years later and identified as synovioma was diagnosed by one pathologist as a hemangio-endothelioma. This would suggest the identity of the second tumor with that of the toe.

Despite the fact that nearly all reported cases have been subjected to irradiation therapy and/or surgery before clinical manifestations of metastases were evident, the results have been extremely poor. Haagensen and Stout[5] question even the palliative value of irradiation. Fisher[6] suggests that local excision of the tumor may contribute to its metastatic dissemination. It is the consensus of most investigators that amputation of the affected limb offers the only

hope of cure. The treatment accorded our patient was similar to that given many of those reported in the literature; for even after the identification of the tumor of the foot as a synovioma, amputation was not performed until one year later.

The favorable, although temporary, results obtained in this instance following irradiation of the pulmonary metastases suggest that extensive irradiation to both local recurrences and metastatic lesions is justifiable in the palliative treatment of synovioma.

SUMMARY AND CONCLUSIONS

1. A case of synovial sarcoma is presented in which local recurrences and metastases to the lungs, heart, brain, spleen and kidneys were observed.
2. The pulmonary metastases regressed measurably following X-ray irradiation.
3. Since synovial sarcoma is uniformly fatal, radical therapy is indicated.

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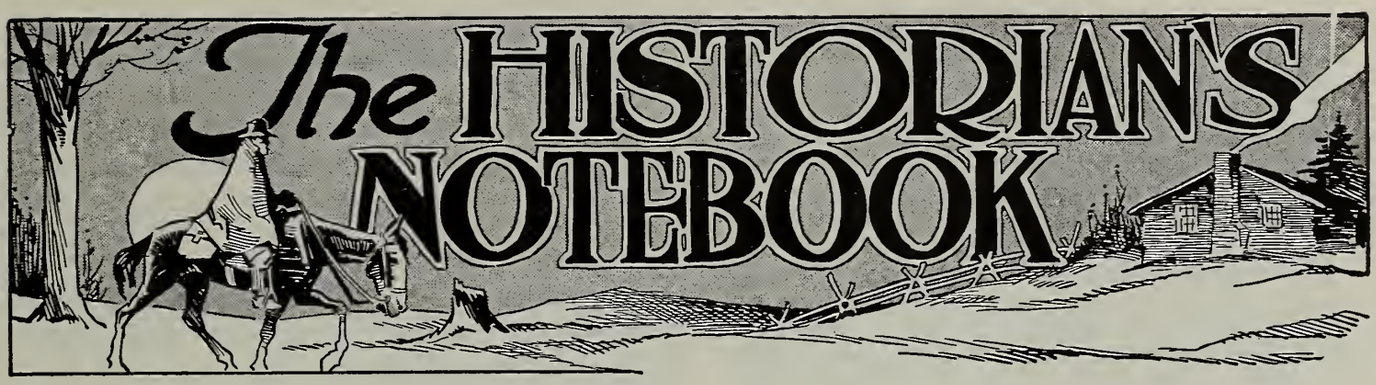
History Taking

In the case of married women, the record of childbirths may be placed either under the family history or following the menstrual history. The data should include the story of miscarriages and abortions, whether these were spontaneous or induced, and their sequential relation to normal pregnancies if such occurred. A history of repeated miscarriages followed by stillbirths and finally by viable children, suggests that the mother is syphilitic. The record of normal births and the intervals at which they occurred should be recorded, and, if birth control has been practiced, the means used, as some methods, particularly withdrawal, may have a deleterious effect on the health of the participants. Furthermore the complications of pregnancy, childbirth and the puerperium should be included in the record, as, for example, birth by forceps, cesarean section, puerperal sepsis, and pre- or post-natal thrombosis and embolism. Especially in difficult or forceps deliveries there may be a story of damage to the child which is significant.—George Blumer, M. D., San Marino, California, Connecticut State Medical Journal, Vol. XIII, No. 7, July, 1949.

Management of Gold Toxicity

The best way of managing the complications of gold poisoning is in preventing them by the proper administration of gold salts. A suggested course of medication using either sodium aurothiomalate (Myochrysine) or aurothioglucose (Solganol-B) is to give 10 mg. intramuscularly once weekly for three or four doses, then 25 mg. weekly to a total of 150 to 200 mg., followed by weekly doses of 50 mg. to a total dose of 1,200 to 1,400 mg. At this point, if the arthritis appears to be under control and no toxic manifestations due to gold are evident, treatment may proceed with 50 mg. given every two or three weeks until a total of 1,800 to 2,000 mg. is reached. Usually at this point the interval between injections can be increased to four to six weeks, the frequency depending upon the symptomatic response. Gold sodium thiosulfate has no known therapeutic advantage over these other water-soluble compounds, and intravenous use of the drug is, therefore, to be discouraged because of the potential danger inherent to all intravenous medication. Before and after the first injection of gold, a count of the blood cells should be made; and thereafter every two to four weeks the blood and urine should be examined. Prior to each injection of gold the patient should be questioned carefully for any evidence of gold poisoning, including dermatitis, pruritus, purpura, stomatitis, nausea, vomiting, jaundice, and diarrhea. Liver function tests are advisable prior to gold therapy, especially if damage of the liver is suspected.

When patients under treatment with gold salts have mild toxic reactions, such as itching, small areas of papular dermatitis, mild stomatitis, transitory increase in joint symptoms, and slight fever following injections, it is not necessary or desirable to use BAL (2, 3-Dimercaptopropanol) at once. It is preferable to stop the administration of gold and observe the patient carefully for several weeks. Should the manifestations of intoxication become steadily worse, treatment with BAL should be instituted. If the signs of intoxication disappear during the interval of observation, gold may be resumed cautiously with smaller doses or sometimes a change to another preparation. If on resumption of chrysotherapy the toxic manifestations flare up again, it is probably best to abandon the use of gold for several months before trying it again. Itching may be treated with a measure of success with the antihistamine drugs—diphenhydramine, tripelennamine and the like—by mouth and in ointments; these drugs do not, however, relieve all patients of itching. Penicillin lozenges apparently alter favorably the course of mild stomatitis.—Wm. C. Kuzell, M.D., San Francisco; California Medicine, Vol. 71, No. 2, August, 1949.



Obstetrics as Taught at the College of Physicians and Surgeons of Columbus, Ohio (1835-1841). Part II.

JONATHAN FORMAN, B. A., M. D., F. A. C. A.

(Continued from September Issue)

ALVA CURTIS and his medical school in Columbus came on the scene at about the right time. The physicians of the regular school had established the basic principles of obstetrics as an application of the newer developments in anatomy and gross pathology. To have appeared later would have been pure quackery, but at this time Thomsonianism grew up as a reforming movement in the healing art. These were the days of the common man. In the democratic spirit of the times, one man's opinion was as good as another. Testimonial evidence was a proper means by which to arrive at the truth.

With the publication of Mauriceau's *Text on Obstetrics* in 1668, this branch of medicine was well on its way to becoming a specialty. Physicians rather than midwives began to assume the leading role, and various medical schools established classes in obstetrics.

This century saw the solution of the problem of placental implantation. Jean Palpy made public his forceps in 1720. William Smellie introduced the steel-lock forceps with the curved and double curved blades. His text (1752) contained the first rules for the safe use of these instruments and a method for pelvic measurements. Johann Huwé (1715) was the first to deal with the obstetrical pelvic clearly and to speak of pelvic inclinations.

The potential changes of the Nineteenth Century were for the most part, the result of serious thought which lead to the triumph of the individual over fixed principles and arbitrary powers. Medicine was caught up in this spirit of evolutionary change and went from metaphysical speculation to the rigid control of the laboratory. The fanciful theorizing of the previous century gave way to an investigation of actual clinical manifestations.

Certainly, the most interesting feature of obstetrical progress in the Nineteenth Century was the development of knowledge relating to puerperal fever—a term first used by Edward Struthers in 1716. The success that Robert Collins had with fumigation and scouring with calcium hypochlorite and the sterilization of the blankets with heat in driving this dreaded disease out of the Dublin Lying-in Hospital could not as yet have been known to Alva Curtis.

It was the very same year (1837) that Curtis' book on *Obstetrics* appeared, that Gittfried Eisenman published his theoretical work in which the theory of the infectious nature of puerperal fever was supported and chlorine douches were advocated as a prophylactic and therapeutic agent. Five years later, of course, Oliver Wendall Holmes published the paper which provoked such a regretable outburst on the part of the "two professors, learned men, both of them skillful experts but babies, as it seems to me, in their capacity of reasoning and arguing."

Being a firm advocate of what he believed to be Nature's method of healing and being compelled to practice obstetrics if he and his students were to set themselves forth as Doctors of Medicine, Alva Curtis was compelled to a rather sound philosophical concept concerning childbirth. In his introduction, he writes:

> "I lay it down as a natural position, on the strength of historical testimony then as well as sound logic, that women are naturally as able as other animals to reproduce their species, without extrinsic aid; that the disabilities with which we actually find them beset are rare, very rare malformations of the system, and more commonly, hereditary cankerous families, but that those by far the most frequently observed are the fruits of bad management in their raising, as comprehended in their clothing, exercise, food, and medical treatment."

This is the basic philosophy exhibited throughout his book. Page after page we find such admonitions as these:

"Unfortunately, for the interest of humanity, it requires more knowledge *not to be officious* than falls to the share of many of those who pretend to practice midwifery." Or again, "Meddlesome midwifery is bad. In labors generally, it is of very little importance whether the practitioner knows or not what is the presentation, because in general, it is a natural one, and notwithstanding his ignorance the child will safely enough come away."

"Rarely is it requested to examine whether the delivery be or be not begun. With the rupture of the membranes, the less you interfere, the better."

Here, then, in Alva Curtis Lectures on Midwifery as delivered to the members of the Bontanico-Medical School at Columbus, Ohio, we got a good insight into the author's mind and life. A brilliant man and a good teacher, he was able to reassure the more timid of the Thomsonian practitioners. And many of these practitioners' main right to practice medicine was their ownership of a patent right to the Thomsonian right which they had purchased from Samuel Thomson, or one of his "agents" (or here in Ohio, Horton Howard). With simple herbs and steam and watchful waiting technique for midwifery, these men were no doubt as efficient and infinitely more safe than the physicians of the regular school of the same vintage.

It was his love of teaching that kept Alva Curtis in hot water. Opening his medical school in Columbus made him the rival of the Reformed Botanics and their school at Worthington. At the same time, his master, Samuel Thomson, who possessed all of the assurance of a Freud, said: "I never knew a single instance when Nature had been assisted according to my practice and the patient had not been able to bear her weight the same day of her delivery." Samuel Thomson could tolerate no extension of his findings. He felt certain that his system of treatment was perfected and could not be improved upon. Consequently, he quarrelled at once with the idea of establishing medical schools.

Thomson was an illiterate man who spurned books. It was only with the greatest of pressure that his agents had persuaded him that a book of instruction must go with the patent rights of his system of healing. He never became confused in his loyalty to himself and his system by reading any of the current medical literature. Curtis on the other hand, was an educated man and by far the most brilliant of several Thomsonian editors. He possessed a rather extensive medical library and kept himself up to date in his efforts to argue with the Reformed Botanics, the Regulars, and the Homeopaths while he persuaded the public to adopt Thomsonianism as their preferred system of healing. Reading Curtis' *Obstetrics* in this light, it becomes quite a remarkable book, one of which he could well be proud.

Both Thomson and Curtis proved to be right. Just as Thomson predicted, those who read the literature would do so because of their wavering faith in the infallibility of Thomsonianism. This was in keeping with the questioning spirit of the times but as Thomson feared it resulted in adding new things to an already perfected system of healing. So it had in it the seeds of self-destruction. Just as Curtis predicted, Thomsonianism also was not able to hold its own unless it too studied and assimulated new knowledge as it emerged in a world where scientific investigations and statistics were becoming the accepted methods of establishing the truth.

Starling Medical College. We wish to call the attention of the people of Franklin and the adjoining counties to the fact that the professors of this institution treat all classes of cases in the medical and surgical line gratuitously on Saturdays of each week. This is done for the instruction of the class of students now in attendance. Persons afflicted with any variety of diseases, by coming here on that day, will have the benefit of the still inexperienced (students) and of the very able and gentlemanly professors. We regard this of much importance to the community, and we hope the intelligence may be very generally diffused.

We append report of cases treated on last Saturday, and shall continue to do so from time to time.

* * *

Nov. 22, J. E., age 7, Fairfield County. Case—Extensive scrofulous development in the lymphatic ganglia. One year ago a large mass of these tumors was removed by operation. At present they developed largely in various parts of the body, and the system in a cachectic condition. His mother recently died of consumption.

Professor Howard remarked that scrofula was an original constitutional debility, and that the morbid deposit consisted in imperfectly vitalized fibran. The treatment consisted in every means, regiminal and medicinal that tended to invigorate and improve the general health, that there were no specifics for scrofula. In this case, nutritious diet, free exercise in the open air, and half a tablespoon full of cod liver oil three times a day were recommended.

* * *

November 23, M. A. L., age 23, male, Delaware County, Ohio. Case—Psoriasis diffusa—four years' standing. Professor Howard said that this was rare in this country, and that it was among the most obstinate of the squamous (or scaly) eruptions. Arsenic in the form of Fowler's solution was recommended as the most reliable and effectual remedy for this affection.

Medical Education . . .

A. M. A. Report Shows Freshman Class of Last Year Was 10 Per Cent Larger Than Average of Prewar Years; School Programs Are Analyzed

SEVENTY-ONE medical schools in the United States are on the approved list of the Council on Medical Education and Hospitals of the American Medical Association, according to the 49th annual report of that council on medical education, which appeared in the September 3 issue of the *Journal of the A. M. A.*

In addition, the Council has approved nine Canadian schools of medicine. It also lists seven approved schools of the basic medical sciences in the United States and one in Canada.

Since publication of the 1948 list, the Chicago Medical School has been added to the approved list and the Hahnemann Medical College, Philadelphia, has been removed from probation.

Approval of the Chicago Medical School applied to all students who were regularly enrolled in the first four years of the medical school course at the time the school was approved in November, 1948. The approval did not apply to previous graduates or to students in the required intern year who had completed their formal training at the school prior to the date on which it was approved. The Chicago Medical School does not grant the degree of Doctor of Medicine until the completion of a year of internship. The first class to graduate as graduates of an approved school will be the one that graduates in the spring of 1950.

The basic science schools of North Dakota and South Dakota remain on probation.

PRIVATE SCHOOLS WANING

Three medical schools formerly privately owned by nonprofit corporations are merging with state universities during the coming academic year. Syracuse University College of Medicine and the Long Island College of Medicine will become parts of the State University of New York. The Southwestern Medical College on September 1, 1949, became a branch of the University of Texas and changed its name to the Southwestern Medical School of the University of Texas.

The merging of these three schools with state universities will reduce the number of medical schools owned by private nonprofit corporations from 44 to 41 and will increase the number of publicly owned schools from 34 to 37.

A table in the report breaks down the enrollment of each of the 71 approved schools with the following totals for the United States: for the academic year 1948-49: Freshmen 6,409; sophomores 5,949; juniors 5,702; seniors 5,086; total 23,146; graduates from July, 1948 to June, 1949, inclusive, 5,094.

An additional 679 students were graduates from Canadian Schools during the same period.

OHIO SCHOOL ENROLLMENTS

The breakdown of Ohio's three schools of medicine was as follows:

University of Cincinnati College of Medicine: Freshmen 90; sophomore 81; juniors 77; seniors 79; total 327; graduates 78.

Western Reserve University School of Medicine: Freshmen 80; sophomores 78; juniors 88; seniors 79; total 325; graduates 75.

Ohio State University College of Medicine: Freshmen 88; sophomores 78; juniors 72; seniors 84; total 322; graduates 84.

All three of the schools require three years of premedical training, according to the report.

Ohio State University College of Medicine graduated its last class on an accelerated program in December, 1948, and graduated a second class on the conventional schedule in June, 1949.

LACK OF DEFERMENT BERATED

As predicted in the 1948 report, the class of 1949 is the smallest graduating class in ten years. The small number of graduates is accounted for by the fact that when this class was admitted to the medical schools during the academic year 1945-46, it was the smallest freshman class since 1940. This class was selected during the last year of the war when there was no provision for the deferment of premedical students by the Selective Service System. As a consequence, medical schools were unable to find a sufficient number of qualified students to fill the available places in their freshman classes.

The enrollments in the senior class for 1949-50 would indicate that there will be approximately 5,600 graduates in 1949-50, which will be a larger graduating class than any except those that graduated in 1946 and 1947 at the culmination of the war time accelerated program when several schools graduated two classes in one year.

Of the total of graduates in the U. S. and Canada, 48.3 per cent possessed a baccalaureate degree. Of the graduates of the three Ohio colleges, the following percentages possessed baccalaureate degrees: University of Cincinnati,

52.6; Western Reserve University, 56.0; Ohio State University, 72.6.

TOTAL ENROLLMENT HIGH

Although the graduating class of the country was unusually small, the total enrollment was the fourth largest in American Medical schools in modern years. The freshman class was the largest class ever admitted to the medical schools of the United States. The total enrollment represents a 10 per cent increase over the average enrollment during the five-year period 1937-41 immediately preceding the war.

In 1948-49 women totaled 2,109, or 8.9 per cent of the medical students in this country.

The percentage of veterans enrolled in the medical schools and schools of basic medical sciences in the United States increased from 60.9 per cent in the preceding year to 65.8 per cent in 1948-49. Veterans comprised 70 per cent of the freshman class, a slight decline from the peak enrollment of 73.4 per cent veterans in the preceding freshman class.

DECRYS PROVINCIALISM

"In the last two Educational Numbers attention has been called to a developing trend for medical schools, particularly those supported by states and municipalities, to limit closely the admission of students to residents of the state in which the schools are located. The statistics for this year indicate that this trend is continuing," the report stated.

"It is well known that this policy does not have the approval of the administrations and faculties of most of the schools concerned. In general restrictions have been adopted as the result of direct or indirect pressure from the governmental agencies controlling the allocation of funds to the institutions," the report continues. "The most serious effect on medicine and medical education of such a policy is the fact that in several states superior out-of-state students are being denied admission in favor of less well qualified resident students. The consequence of this development is to lower the caliber and qualify of the medical profession particularly in the states that apply such restrictions."

For the nation as a whole there were 4.7 freshman medical students per hundred thousand inhabitants. Those states with medical or basic science schools had an average of 5.2 students per hundred thousand of population enrolled as freshmen. Ohio had an average of 4.5 freshmen medical students per hundred thousand population.

Of the total of 2,801 freshman students admitted by state and municipal schools during the current year only 229, or 8.2 per cent, were nonresidents. Two years ago 14.8 per cent of freshman students in these schools were nonresidents, while last year only 9.8 per cent were out-of-state students. In 1941-42 the last prewar year, the freshman enrollment of the state the municipal schools included 17.4 per cent of out-of-state students.

The privately owned medical schools admitted a total of 3,887 students during the current year. The number of out-of-state students in this group was 1,980, or 50.9 per cent. Last year the freshman classes in this group of schools had 51.3 per cent of nonresidents and in the previous year 51.4 per cent. In 1941-42, these schools enrolled 52.9 per cent nonresident students.

Although the Ohio schools admitted 258 freshman students during the academic year, there was a total of 344 student residents of Ohio who entered freshman classes throughout the United States and Canada.

Ohio residents registered as freshmen were in the following schools: College of Medical Evangelists, 2; Yale University School of Medicine, 1; Georgetown University School of Medicine, 4; George Washington, 5; Howard University, 1; Chicago Medical School, 2; Stritch School of Medicine of Loyola Universty, 10; Northwestern University, 8; Unversity of Chicago, 1; University of Illinois, 1; Indiana University, 1; Johns Hopkins University, 2; University of Maryland, 3; Harvard, 6; University of Michigan, 6; St. Louis University, 21; Washington University, 1; Dartmouth, 3; Albany Medical College, 1; Long Island College of Medicine, 1; University of Buffalo, 5; Columbia, 4; Cornell, 5; New York Medical College, 4; University of Rochester, 4; Syracuse, 2; Duke, 3; University of Cincinnati, 70; Western Reserve University, 51; Ohio State University, 88; Hahnemann Medical College, 5; Jefferson Medical College, 4; Temple University, 3; University of Pennsylvania, 3; Woman's Medical College of Philadelphia, 3; Meharry Medical College, 4; Marquette, 4; McGill, 2.

Seven schools in the United States and three in Canada require their students to serve an internship.

Forty medical schools in the United States reported a total of 1,697 physicians enrolled in formal basic science courses in preparation for certification by a specialty board. This total does not include persons reported under the category of physicans workng for advanced degrees who might also be preparing for certification.

Forty-nine medical schools in the United States reported a total enrollment of 15,695 physicians in refresher or continuation courses. Five Canadian schools reported a total enrollment of 691 students in courses of this type.

Industrial Commission . . .

$4,515,016 Disbursed by Ohio Agency for Medical Services in 1948, Report of Actuarial Section Shows; Claims Filed Totaled 301,053

THE Industrial Commission of Ohio paid out $4,515,016 for medical services to injured Ohio workmen during 1948, according to a report issued recently by H. H. Pickering, supervisor of the Actuarial Section. Included in the amount is a relatively small sum for dental services.

Other expenditures during the year, exclusive of compensation payments, included: $3,085,151 for hospital care and nursing; $165,863 for funeral expenses, and $110,444 for miscellaneous costs. With disbursements for medical services added, the total is $7,876,474.

These amounts include payments covering treatment of injured private and public employees, as well as similar costs for occupational disease claims.

Comparative figures for 1947 were as follows: $4,225,956, medical services; $2,556,431 for hospital care and nursing; $126,032, funeral expenses; $76,357 miscellaneous costs—a total of $6,984,776.

SLIGHT RISE IN CLAIMS

The number of claims filed during 1948 was 301,053, or three per cent higher than in 1947. The peak year in number of claims during the 37-year history of the Ohio Workmen's Compensation Fund was 1943 when the number of claims reached 331,072, 81 per cent of which were "medical-only" claims. The average number of claims filed each working day in 1948 was 1,204.

"Medical-only" claims, involving payment for physicians' services, but with no compensation to the claimant for loss of time, numbered 236,050 in 1948, or 78 per cent of all claims filed.

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION

As of December 31, 1948

ASSETS

	Private	Public	P. W. R. E.	Safety & Hygiene	Total
Cash	$ 3,680,038.58	$ 166,019.19	$ 25,386.33	$ 39,355.98	$ 3,910,800.08
Bonds	151,840,777.34	7,521,024.89	742,418.77	1,291,163.07	161,395,384.07
Premium in Course of Collection	2,673,748.17	1,199,381.58	1,129.87	----------	3,874,209.62
Interest Accrued	593,842.87	29,414.41	2,903.57	5,049.68	631,210.53
Total Assets	$158,788,406.96	$8,915,790.07	$771,838.54	$1,335,568.73	$169,811,604.30

LIABILITIES

Reserve for Compensation & Medical Benefits	$100,076,743.76	$6,797,780.82	$110,430.00	----------	$106,984,954.58
Reserve for Contingencies	18,500,000.00	1,250,000.00	20,500.00	----------	19,770,500.00
Unearned Premium	9,296,617.00	----------	----------	----------	9,296,617.00
Fund Account	----------	----------	----------	1,335,568.73	1,335,568.73
Surplus	30,915,046.20	868,009.25	640,908.54	----------	32,423,963.99
Total Liabilities	$158,788,406.96	$8,915,790.07	$771,838.54	$1,335,568.73	$169,811,604.30

TABLE 2

1948 Disbursements Distributed to Year of Injury Occurrence

(Accidents and Occupational Disease Combined)

Year of Accident or Disease	Compensation	Medical Hospital, etc.	Total	Per Cent
1948	$ 4,029,626	$ 3,671,133	$ 7,700,759	28
1947	4,659,241	2,408,204	7,067,445	25
1946	2,875,592	402,580	3,278,172	12
1945	1,900,975	204,144	2,105,119	08
1944	1,647,861	140,036	1,787,897	06
1943	1,253,864	109,795	1,363,659	05
1942	923,620	55,951	979,571	04
1941	594,524	52,451	646,975	02
1940	339,625	60,253	399,878	01
1939	165,535	27,790	193,325	01
1912 - 1938	2,006,237	236,038	2,242,275	08
Total	$20,396,700	$ 7,368,375	$27,765,075	100

The average amount paid out per "medical-only" claim decreased from $10.11 in 1947 to $10.01 in 1948.

CONDITION OF FUND

During 1948 the surplus of the fund concerned with private employees increased $1,449,539.76, resulting in a total surplus of $30,915,046.20. The total assets increased $2,232,223.95, bringing the accumulated amount to $158,788,406.96, a new high in the history of the fund.

BASIC RATE CHANGES

Basic rates were lowered in 269 classifications, raised in 46, and remained unchanged in 17, according to the *Actuarial Review.*

Table 1 is a financial statement of the Ohio State Insurance Fund.

Table 2 gives 1948 disbursements that have been paid for active claims according to year of injury, and having injury dates which in some instances reach back to the beginning of the fund.

Radiological Society To Meet In Cleveland, Dec. 4-9

"Diagnosis and Treatment of Malignant Tumors" will be the theme of the 35th annual meeting of the Radiological Society of North America according to Dr. Edgar P. McNamee of Cleveland, president of the society.

The convention, scheduled for December 4 to 9, will be held in Cleveland with headquarters at the Public Auditorium and the Statler Hotel.

Heading the executive committee on local arrangements is Dr. Harry Houser of Cleveland. He reports arrangements are well advanced promising our outstanding program. Carefully planned refresher courses, and scientific and commercial exhibits are included in the over-all plan. Special emphasis is being placed on large-scale exhibits.

Life Expectancy More Than Two Years Better Than in Prewar Years

Latest available figures show that the average length of life of the people of the United States is nearly two years above the level reached in the three years just before the war, the Federal Security Administration announced.

White women, on the average, live longer than any other single group, leading white men by more than five years. Average life expectancy for white women at birth is 70.6 years, while the average for men is 65.2 years.

The average for the total population in the United States in 1947 was 66.8, the non-white population having a lower but steadily increasing life expectancy. The figure for non-white women in 1947 was 61.9 and for non-white men 57.9.

Licensed Through Endorsement By State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

June 17, 1949—J. Fletcher Robinson, Mt. Vernon, Albany Medical College; **Ralph G.** Rohner, Columbus, Med. College of Virginia; Gilbert J. Sheekley, Akron, St. Louis Univ.

August 2, 1949—Robert E. Allen, Cleveland, Univ. of Pa.; Charles V. Bowen, Jr., Akron, Univ. of Maryland; Richard H. Breece, Columbus, New York Univ.; Edward S. Bundy, Columbus, Univ. of Vermont; Irving H. Chevlen, Youngstown, Univ. of Minn.; H. Robert Coler, Columbus, Univ. of Berlin; Thomas F. J. Connell, Shaker Heights, St. Louis Univ.; Robert D. Crouch, Cambridge, Medical College of S. C.; Robert A. Davison, Shreve, Wayne Univ.; Maier M. Driver, Cleveland, Univ. of Buffalo.

Thomas A. Ferguson, Upper Sandusky, Univ. of Louisville; Frank E. Foss, Toledo, St. Louis Univ.; Arnold Friesen, Cleveland, Univ. of Nebraska; Mortimer A. Gallagher, Columbus, Harvard Univ.; Paul E. Geiger, Toledo, Loyola Univ.; Cyril V. Gross, Canton, Hahnemann Medical College; William G. Halley, Cleveland, Univ. of Mich.; Hubert L. Harris, Canton, State Univ. of Iowa; Donald H. Haselhuhn, Toledo, Tufts Medical School; Karl Horn, Lima, Univ. of Dusseldorf, Germany; Ernest A. Kellen, Columbus, St. Louis Univ.; Carl H. Laestar, Portsmouth, Med. College of Va.

Charles H. Maly, Sardinia, Indiana Univ.; Edward P. McCreery, Jr., Cleveland, Univ. of Va.; Stuart F. Meek, Cleveland, Wayne Univ.; Whitney H. Missildine, Columbus, State Univ. of Iowa; John H. Monroe, Cincinnati, Harvard Univ.; Evan G. Moore, Cleveland, Meharry Medical College; Raymond J. Murphy, Carey, St. Louis Univ.; James F. Poe, Tiffin, Univ. of Arkansas; Charles E. Richards, Cleveland, Univ. of Nebraska; Leonard R. Robbins, Cleveland, Baylor Univ.; John M. Roll, Dayton, St. Louis Univ.; Wm. S. Rothermel, Canton, Jefferson Med. College.

Douglas B. Scott, Columbus, Howard Univ.; Robert S. Stockton, Cleveland, Univ. of Buffalo; Edgar A. Stone, Cleveland, Western Reserve Univ.; Robert E. Suer, Cincinnati, Indiana Univ.; Harold H. Teitelbaum, Youngstown, Royal College of Physicians and Surgeons, Edinburgh, Scotland; Edward M. Thomas, Youngstown, Northwestern Univ.; David H. Watkins, Columbus, Univ. of Colorado; Richard N. Westcott, Cincinnati, Harvard Univ.; Philip T. White, Rocky River, George Washington Univ.; Joseph P. Whitlatch, Columbus, Georgetown Med. School; Richard H. Williamson, Huron, Univ. of Rochester.



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Social Security May Be Expanded . . .

Predictions Are That Professional Men May Be Included in Program; Other Provisions May Be Wedges for Compulsory Insurance Scheme

WASHINGTON observers predict expansion of the Federal Social Security Program by the Congress in 1950—an election year.

Legislation which may be enacted would be of vital importance to members of the medical profession for several reasons. It might force all of the self-employed, including physicians, into the Social Security Program. Professional men are not included now, nor in a bill recently drafted by the House Ways and Means Committee—but they might be included in revised drafts. It might include a system of temporary disability insurance which would be of indirect interest to the medical profession, if for no other reason than it could be a forerunner to compulsory sickness insurance. It might even include provisions for compulsory sickness insurance. It would call for increased payroll and probably direct taxes, which affects physicians as substantial taxpayers and employers of labor.

What can be expected if the plans of some Congressional leaders and the Administration materialize was summarized in excellent fashion in a recent article in *U. S. News and World Report*, a reliable reporter on Washington trends and events. The following is quoted from that article:

"**Taxes,** under the proposed law, will rise gradually between now and 1970. By that time, rates are scheduled to be more than three times the current level of two per cent—half each on employer and employe.

"**Next January 1,** the rate rises from two per cent to three per cent, shared by employer and employe. This is automatic under present law.

"**In 1951,** under the bill expected to become law in 1950, the rate goes to four per cent, equally divided. At the same time, the tax becomes applicable to the first $3,600 of income. It now applies to only $3,000.

"**In later years,** the tax continues to rise. It goes to five per cent in 1960, to six per cent in 1965 and to six and one-half per cent in 1970. The tax will continue to be split between employer and employe.

"For self-employed persons who are to be added to the program, the rate starts out at two and one-fourth per cent, then rises to three per cent in 1951, to three and three-fourths per cent in 1960, to four and one-half per cent in 1965 and to 4.875 per cent in 1970. These rates are to apply against the first $3,600 of income.

"New groups to be added to the insurance system include around 11,000,000 persons. They are about 4,000,000 businessmen and other self-employed persons, 4,000,000 State and local-government employes, 600,000 employes of non-profit institutions, 750,000 domestic workers, 100,000 federal employes not now covered by retirement systems, 50,000 miscellaneous workers and 500,000 to be brought in under a broader definition of the term 'employe,' including commission salesmen, some taxi drivers and others.

"Lawyers, doctors and other professional men, except those working for salaries, are excluded. So are farmers, farm workers and ministers. State and local government employes will be brought in only in cases where States enter into an agreement with the Federal Government.

"**Benefits** are raised by about 80 per cent on the average.

"Minimum monthly benefit is increased from $10 to $25.

"Maximum benefit for a family is raised from $85 to $150 a month.

"Retirement age remains at 65 years. After retirement, a person can earn as much as $50 a month and still draw his benefits. Under present law, a person loses his benefits if he earns more than $14.99. The new bill provides that after a retired worker reaches 75 he can draw his benefits regardless of earnings.

"Permanent and total disability will entitle a person to the same benefits as if he had retired.

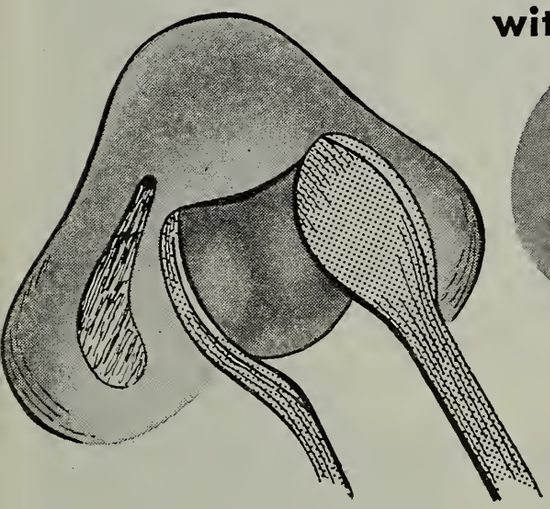
"In figuring the amount of benefits to which a person is entitled, the average wage will be calculated on the whole period of the Social Security program or on only the period after 1949, whichever is more favorable to the worker.

"To protect veterans, a provision is included to assume, for purposes of the Social Security system, that for the whole period of military service they earned $160 a month in covered employment.

"**The new program,** as set up in this bill, goes a long way toward the old-age insurance proposals submitted by President Truman early this year. New insurance programs urged by Mr. Truman have found less support in Congress. These are systems of health and temporary-disability insurance. Enactment of these programs in 1950 seems doubtful."

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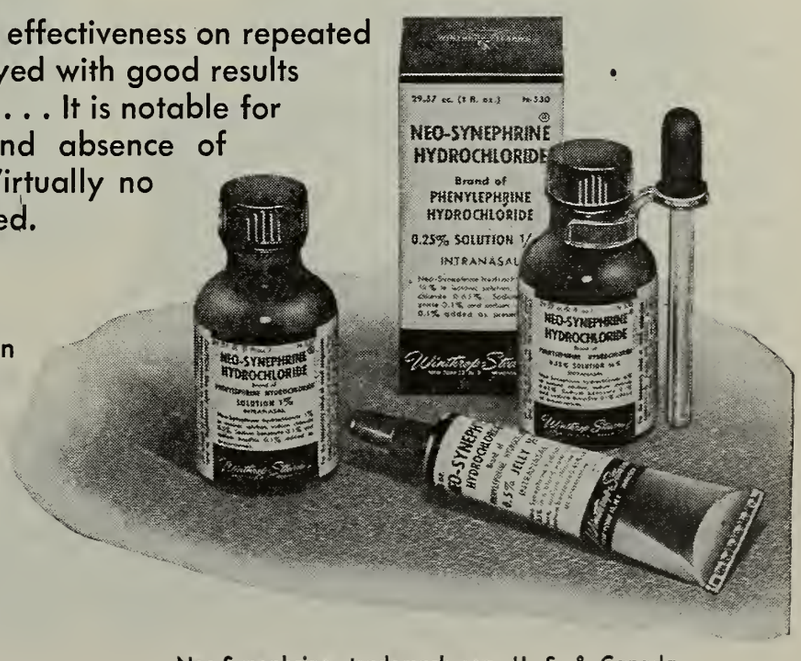
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Ohio Vital Statistics . . .

1948 Report Shows Births Second Only to 1947 High While Deaths Reach All-Time Low; Tuberculosis and Maternal Deaths Lowest Ever

ON the basis of relationship of births and deaths, Ohio's population increased by 105,177 during 1948, according to the Annual Vital Statistics Report of the Ohio Department of Health.

While the death rate of 10.32 per thousand population was the lowest in the State's history, the birth rate of 23.82 per thousand population was the second highest. The number of births was 185,696—second only to the record high of 197,296 during 1947.

While Ohio's birth and death rates followed the same annual trends of the nation from 1933 through 1946 (the last year for which national figures have been published), the birth rate in Ohio has been slightly lower and the death rate slightly higher than those for the country as a whole.

The trend toward increasing numbers of births in hospitals continued with a record rate of 93.39 per cent. In 1947, 92.45 per cent of births occurred in hospitals.

Three out of four deaths were from the same "10 leading causes" which have topped the list for years. Tuberculosis, with a record low of 27.39 per 100,000 population moved from sixth to seventh place on the list. This is the first time that the rate fell below a rate of 30.0.

Diseases of the heart predominated the list as usual with a rate of 339.26 deaths per 100,000 population.

TEN LEADING CAUSES

The ten leading causes of deaths, with rates per 100,000 population, were as follows: Diseases of the heart, 339.26; cancer, 144.98; cerebral hemorrhage, 102.87; nephritis, 55.88; pneumonia, 33.03; diabetes mellitus, 29.81; tuberculosis, 27.39; premature births, 24.91; automobile accidents, 21.85; falls, 20.81.

The rates during 1947 were as follows: Diseases of the heart, 343.10; cancer, 143.24; cerebral hemorrhage, 109.17; nephritis, 60.92; pneumonia, 38.08; tuberculosis, 30.80; diabetes mellitus, 30.15; premature births, 27.75; automobile accidents, 21.93; falls, 20.99.

There was a slight increase of one per cent in the cancer rate. The rates for diabetes mellitus, automobile accidents, and falls remained approximately the same. There were decreases in the rates for other leading causes as follows: Heart diseases, 1.2 per cent; pneumonia, 13 per cent; tuberculosis, 12 per cent; premature births, 10 per cent; nephritis, 8 per cent, and cerebral hemorrhage, 5 per cent.

OTHER CAUSES

Other selected causes of deaths, with the rates per 100,000 population were as follows: Diseases of the blood and blood-forming organs, 8.26; diarrhea and enteritis (under 2 years old), 5.08; diarrhea and enteritis (over 2 years old), 0.88; non-malignant and unspecified tumors, 3.69; influenza, 3.36; acute poliomyelitis, 1.12; acute rheumatic fever, 0.58; all accidents (including automobile), 69.64.

Poliomyelitis, while still far down the list as cause of deaths, showed more than 100 per cent increase over the previous year. The number of deaths was 87 in 1948 against 43 recorded in 1947.

The highest increase in any category was in diarrhea and enteritis in children under 2 years old. The rate was 104 per cent higher than in 1947. A total of 396 children died from this cause, the great majority of them in the less populated areas.

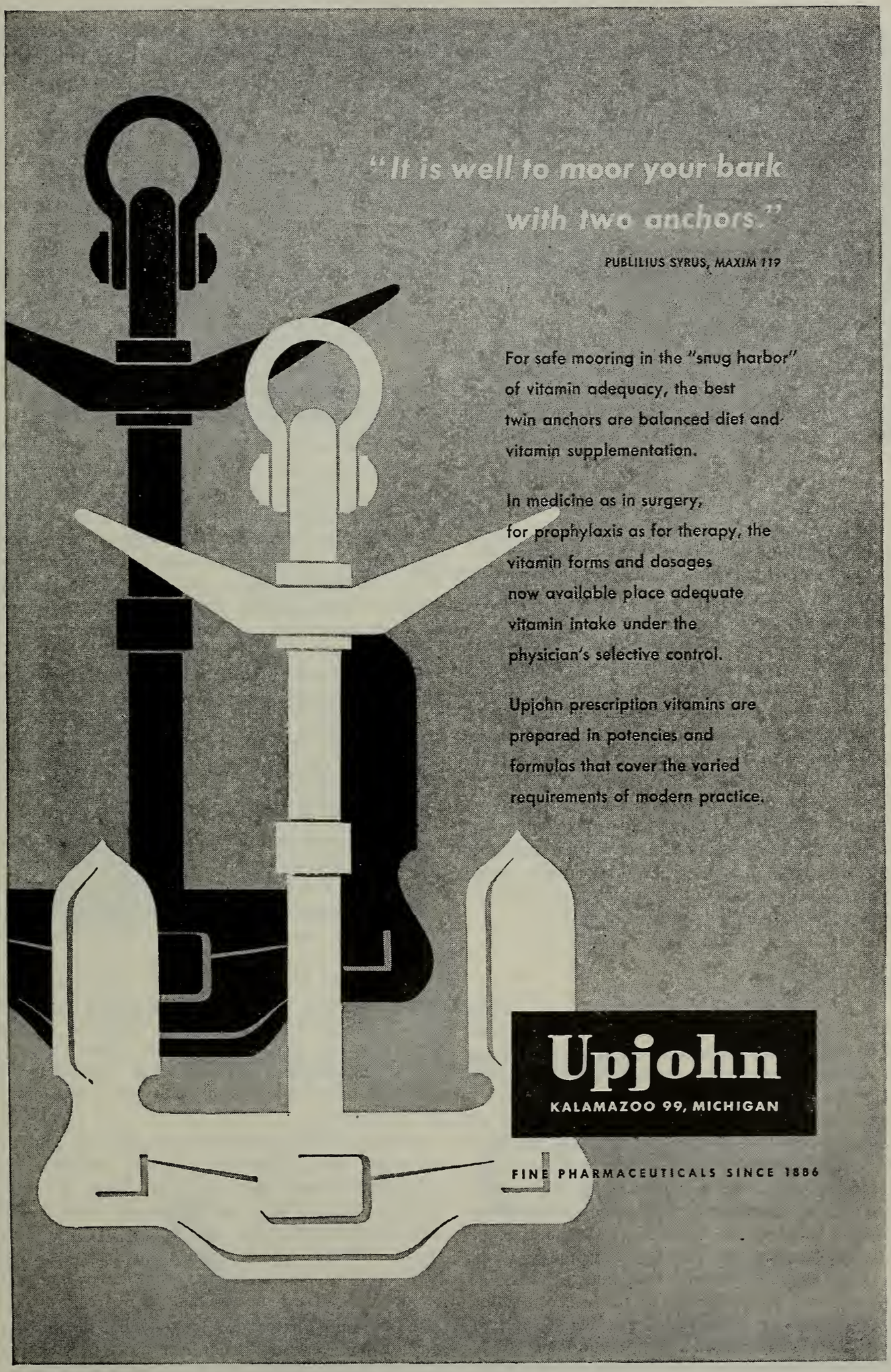
MATERNAL-INFANT

Maternal deaths reached an all-time low with a rate of 0.84 per 1,000 live births. With the trend generally downward for many years, the previous low was reached in 1947 with a rate of 1.12 per 1,000 live births.

The rate of neonatal deaths (under 1 month) was 21.61 per 1,000 live births, a slight decrease. Stillbirths amounted to 20.91 per 1,000 live births, another slight decrease. Infant deaths (under 1 year) amounted to 30.56 per 1,000 live births, a slight increase over the previous year's rate of 29.53. Health authorities believe the slight increase in infant deaths is due partly to a carry over from the 1947 record birth rate.

Ohio Society for Crippled Children

The 30th Annual Meeting of The Ohio Society for Crippled Children will be held October 16-17 at the Deshler-Wallick Hotel, Columbus. National and state authorities on various phases of physical handicap will take part in the two-day program, which will also include election of officers and annual membership meeting.


"It is well to moor your bark with two anchors."
PUBLILIUS SYRUS, MAXIM 119
For safe mooring in the "snug harbor" of vitamin adequacy, the best twin anchors are balanced diet and vitamin supplementation.
In medicine as in surgery, for prophylaxis as for therapy, the vitamin forms and dosages now available place adequate vitamin intake under the physician's selective control.
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

PRESENT FIGHT NOT "MEDICAL POLITICS"

Dr. M. A. Blankenhorn, head of the Department of Medicine, University of Cincinnati, and recent chairman of the Section on Internal Medicine of the A. M. A., in a letter to the Editor of the *Cincinnati Journal of Medicine*, takes issue with certain newspaper columnists who labeled the June meeting of the A. M. A. a "political caucus."

Dr. Blankenhorn states that he "denies that medical politics spoiled the A. M. A.—but he agrees with the *New York Times* in that medical politics can spoil any medical society and that the surest way to do it is to put the U. S. Government into the practice—and the teaching of medicine."

Those who are as familiar with the scientific and educational activities of the A. M. A. as Dr. Blankenhorn will agree with him. Only the uninformed or misinformed look upon the A. M. A. as a group of "medical politicians."

Also, the well-informed know that the present battle of the A. M. A. against powerful political forces is, in the final analysis, a fight to preserve scientific and professional freedom for the medical profession so it can continue to make lasting contributions for the benefit of the American people.

Surely, such a fight deserves the active personal and financial support of every physician who wants to see medicine progress—in fact the support of any citizen who wants to see medicine advance in its age-long campaign to improve health conditions and health standards.

OHIO DRUGGISTS JOIN A. M. A. CAMPAIGN

The Ohio State Pharmaceutical Association has requested its members to take an active role against compulsory sickness insurance legislation by distributing A. M. A. educational campaign literature to their customers. Samples of literature, supplied by the Ohio State Medical Association, has been sent to hundreds of Ohio pharmacists, with an order blank for obtaining literature in quantities, without cost, from the Columbus Office of the State Medical Association.

The cooperation of Ohio's pharmaceutical organization is appreciated. Obviously, the druggists, as well as all professional and businessmen, have a big stake in the outcome of the present drive to socialize American business and professional interests. Nevertheless, their willingness to do something about it is encouraging. Here's hoping other business and professional groups will follow their example.

Are there business and professional groups in your community who should be doing something about stopping the left-wingers but who are sitting back, letting the other fellow do all the work? If so, it's time for you—and every other physician—to call them on the carpet and put them to work.

CLOSE CHECK ON NEW W. C. PROCEDURE ADVISED

An amendment made in the Ohio Workmen's Compensation Law by the 98th General Assembly relieves employers from reporting accidents unless the accident results in seven or more days of total disability to the injured workmen. Previously, all accidents incurred by workmen while on the job had to be reported to the Industrial Commission. The amendment will relieve employers of considerable bookkeeping and filing.

However, employers, employees and physicians should not be misled by this new provision.

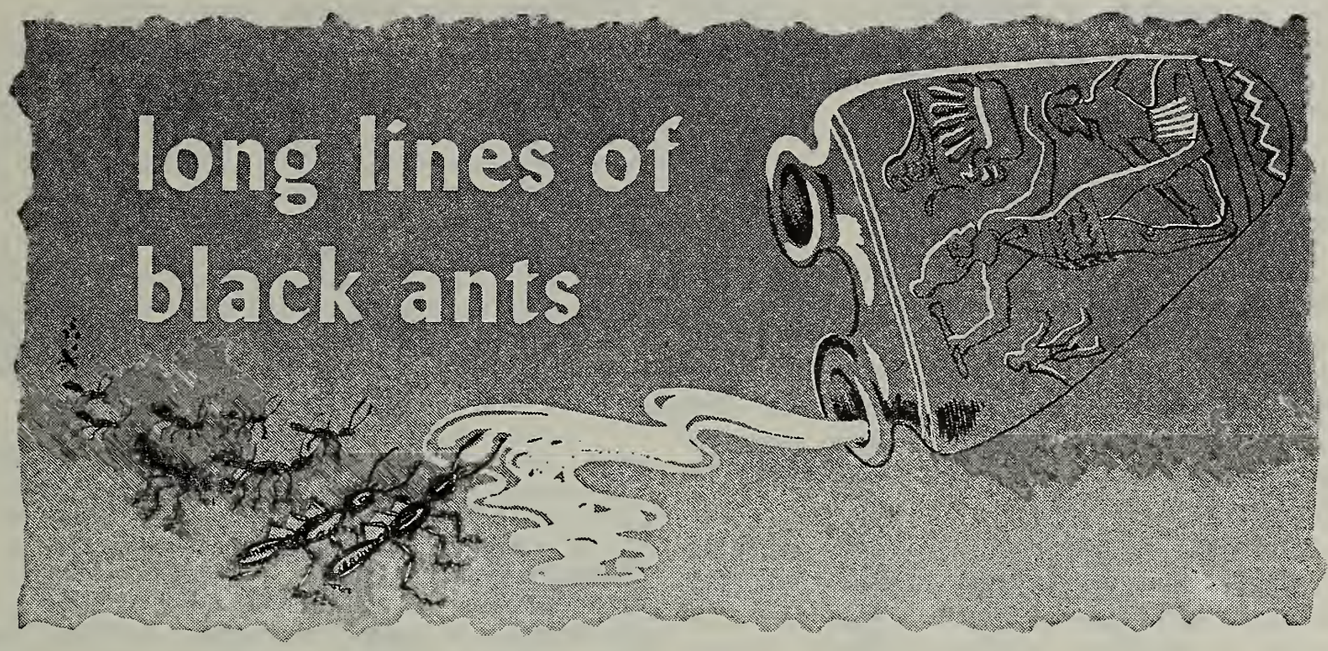
All workmen who are injured while working will still be entitled to medical care at the expense of the Workmen's Compensation Fund, or at the expense of the employer, regardless of the length of the disability.

If an injured workman wants the Commission to finance his medical bills, he and the employer must file a C-3 (pink) medical only blank.

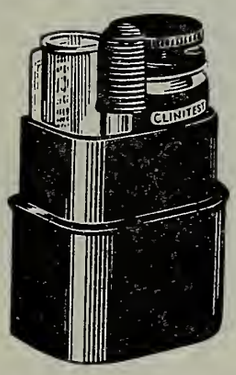
If the employer wants to pay a physician direct for services rendered to a workman when the disability is less than seven days, he may do so, and need not file a claim blank with the Commission nor report the accident to the Commission. Obviously, he would be expected to pay the attending physician at least what the uniform Workmen's Compensation medical fee schedule provides or fees otherwise satisfactory to the doctor.

If the employer does not pay the bill and no claim is filed, then the injured workman is obligated to pay the physician from his own pocket. Few, if any, workmen will want to do this—in fact they are not expected to do this as the Workmen's Compensation Law sets up coverage for such matters, whether or not the accident is trivial or serious.

It might be wise for physicians to keep a close check on how this new provision works out; to discuss it with workmen who request at-



Long lines of black ants attracted to madhumeha, "honey urine," led the ancient Hindu wise men to observe and recognize diabetic urine, which they described as "astringent, sweet, white and sharp." Avid insects became an acknowledged means of diagnosis. Almost equally primitive methods of urine-sugar detection remained in effect for a score or more of centuries, until modern copper reduction tests were perfected, refined and simplified.



Simplest of all today is the reliable *Ames* tablet method, performed in a matter of seconds. Urine-sugar levels are determined by direct, easily-learned steps. The use of *Clinitest* (Brand) reagent tablets has eliminated the inconvenience of external heating. Interpretation of routine urine-sugar testing follows readily from color scale comparison.

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tention for minor and trivial injuries resulting from employment. If difficulties arise, physicians should notify the Columbus Office of the Ohio State Medical Association so the matter can be taken up with the Commission.

WHAT ABOUT TEXTBOOKS USED IN YOUR SCHOOLS?

Doubtless, a good bit of collectivism and socialistic bunk is being handed out in textbooks used in some of the public schools and colleges in Ohio. In fact, we know this is the case. We've seen some of it; we've heard physicians talk about it after looking over the books which their youngsters bring home for home-work.

But, what are we doing about it—assuming, of course, that we as good citizens think that propaganda for such doctrines should not be spread in our schools and that reference to them should be kept on an objective basis?

Here's a job for each physician. Many of you are members of local boards of education. You can have plenty to say about this. Many of you are members of a Parent-Teacher Association. You can make your influence felt there. Most of you are members of local civic clubs or organizations which should be interested in a house-cleaning along these lines. A little prodding by you might work wonders.

How about it? Find out what kind of textbooks are being used in your community schools. If they are full of leftish propaganda, put the heat on the proper authorities to have them eliminated.

If you want some authentic information on how textbooks stack up, subscribe ($2.00 per year) for *The Educational Reviewer*, a new quarterly pamphlet being issued by the Conference of American Small Business Organizations. It evaluates books being used for teaching purposes. The Reviewer's address is 112 East 36th Street, New York 16.

BRIBE CHARGE BY CNH DRAWS HOT REPLY

In our opinion, Mr. Chat Paterson, who is handling the propaganda for the Committee for the Nation's Health, left-wing group which is plugging for the Truman compulsory sickness insurance scheme, overplayed his hand when he charged recently that the medical profession is trying to bribe the newspapers of the country. Mr. Paterson tried to run a bob-tail straight. He has been called—and how.

The new fracas stirred up by Paterson, with *CIO News* in the cheering section, is adequately described in the following article from the August 20 issue of *Editor and Publisher*, official Fourth Estate magazine. Read it and let Mr. Paterson do the weeping. Quote:

"The Committee for the Nation's Health, advocate of the Truman health program, has distributed a press release asserting that the Minnesota State Medical Association had let down the barriers for advertising by doctors 'as an open bribe to the press of the state.'

"*CIO News* has given prominent play to the release, drawing a sharp editorial reply this week from the *Minneapolis Tribune* which charges 'preposterous distortions' of the medical group's recent action.

"The Tribune said, in part:

"'Action of the House of Delegates clears the way for county medical societies to buy newspaper ads in order to present their side of the health insurance debate. This they have every right to do, as editors pointed out at a state-wide medical-press conference April 8.

"'Purchase of newspaper advertising space, however, in no sense constitutes a subsidy. Such space is available to all reputable advertisers including doctors and medical societies or any other group wishing to support or oppose socialized medicine. Nor does purchase of advertising space include the right to dictate editorial policy of the newspaper.

"'Any doctor who assumes that by buying space to argue the case against socialized medicine he is also paying the newspaper editor to support his cause in the editorial columns, is utterly wrong. Perhaps the editor agrees that socialized medicine is bad for the country. But if he does there is no more reason to believe he has been "bribed" by the doctor than to believe he has been bribed by the grocer, who also advertises and who happens to agree with the editor's position on aid to Europe.

"'Any editor, who believes he must oppose socialized medicine in order to sell advertising space to the local medical society is not worthy of the position of influence and responsibility he holds in his community. He is violating the ethics of his profession just as surely as the doctor who performs illegal operations. Certainly he cannot speak for the press as a whole or as a representative Minnesota editor.'

"Chat Paterson, executive director of the CNH, said in the Washington press release that organized medicine has sacrificed the time-honored practice of barring paid advertisements by doctors to gain 'indirect publicity' for its campaign against compulsory health insurance.

"Mr. Paterson's office made available photostatic copies of material issued by the Minnesota Editorial Association pertaining to the Medical Association's resolution permitting doctors to place a professional card in the local newspaper. The size of the card ad is restricted to one-column by two inches.

"Local medical societies were allowed to buy unlimited space for special greetings, messages, announcements and other material.

"The MEA report to members was prefaced with this statement: 'We fervently hope that enthusiasm over relaxed medical ethics will not encourage even the momentary impairment of newspaper ethics.'

"A letter from the president of the State Medical Association to local societies was quoted

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AUREOMYCIN HYDROCHLORIDE LEDERLE

Aureomycin is now generally accepted as one of the most versatile antibiotics yet isolated. In addition to attacking the Gram-positive cocci with great effectiveness, it is useful against many Gram-negative organisms, particularly those of the coli-aerogenes group. It is also effective against rickettsial infections and certain diseases of unknown etiologies, such as primary atypical pneumonia. Aureomycin in solution with sodium borate has been found highly effective in the eye in a concentration of one-half per cent. Among others it is active against the diplobacillus of Morax-Axenfeld, Friedländer's bacillus, staphylococcus, pneumococcus, and *Hemophilus influenzae*.

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as saying: 'While the income from such advertising probably will not be appreciable, newspapermen recognize the resolution for what it is, a genuine interest in working with the press.'

"The MEA offered an ad in the *St. Cloud Daily Times* as a sample of the type of copy that could be reproduced in newspapers. It bore the signatures of 69 doctors, urging public protest against the bills in Congress."

As we see it, the affair boils down to this: Purchase of paid advertising by medical societies is nothing new; had been done many times for years in many areas; is not a violation of medical ethics. Publication of dignified professional cards by physicians has been an acceptable custom in some localities; is not a violation of medical ethics, providing the notices do not promise cures, do not boast, and do not make exaggerated or fraudulent statements. Therefore, what has happened in Minnesota is nothing new—nothing to get excited about—doesn't disturb anybody but the CNH and Mr. Paterson.

DEM BIG-WIGS SPANKED BY PHYSICIAN-COMMITTEEMAN

Democratic Party leaders who have been trying to make it appear as if the Democratic Party is an all-out supporter of the Truman compulsory sickness insurance scheme, despite the fact that thousands and thousands of members of that party are known to be vigorous opponents of this and other socialistic do-dads, were given a sound verbal spanking at a recent meeting of the Democratic National Committee in Washington.

The spanking was administered by Dr. R. B. Robins, Camden, Arkansas, Democratic national committeeman and member of the coordinating committee supervising the educational campaign of the American Medical Association.

Dr. Robins filed a statement with the committee in which he criticized some of his committee colleagues and charged "misuse of the good offices of this Committee in support of agitation for compulsory health insurance."

Endorsement of compulsory health insurance, Dr. Robins charged, threatens to "read out" of the Democratic party hundreds of thousands of persons now on record as opposing government control of medicine.

He stated further that agitation for socialized medicine by members of the Committee is "reckless and unauthorized."

"The Democratic party," Dr. Robins explained, "is not on record in its party platform as favoring Compulsory Health Insurance. At the Philadelphia convention last year, the Democratic party announced support of a National health program for expanded medical research, medical education and hospital and clinic facilities. This does not constitute endorsement or recommendation of compulsory health insurance.

"The Compulsory Health Insurance issue is a bad penny that turns up every few years. It has never obtained sufficient support to merit incorporation in the platforms of either of the major political parties. It has never obtained sufficient support to be legislated in Congress.

"Not only are hundreds of thousands of physicians and dentists opposed to Government-controlled medicine, but there are more than 1500 civic, service, veteran and other organizations, with memberships totaling millions, that have gone on record against it.

"Do we (the Democratic party) want to serve notice on these millions that they are not wanted by this Party because they have gone on record against socialized medicine? Compulsory health insurance is repugnant to the ideals and convictions of the American people."

There are many physicians in Ohio and throughout the country, who are active, long-time members of the Democratic Party. Doubtless, many of them are not happy about the attitude of some of the party big-wigs on this issue.

Since political activity stems from the grass roots—or should—it might be advisable for them to have a heart-to-heart talk with their local party leaders on this matter. National leaders are too smart to battle a real tide of adverse local sentiment and opinion. Therefore, how the party leaders in your community feel about the matter is important. Your immediate job is to see that they are properly informed and advised, and that they also file protests with the National Committee.

MAKING OR BREAKING THE PREPAID PLANS

The following is quoted from the President's Page of the *News Letter* of the American Society of Anesthesiologists, over the signature of Dr. H. Boyd Stewart, president of that society:

"From many sources over the United States, I am hearing increasingly numerous reports that surgeons and anesthesiologists are being cited in contempt by the public in their relations with patients who are insured under Blue Cross and Blue Shield Plans. The universal charge against the physician is that he is guilty of exploitation of his patient by accepting a fee from a prepayment plan and then charging the patient a private fee as large as he was accustomed to levy before the patient had insurance. More than half the Blue Shield Plans in operation are on an indemnity basis, permitting the physician to charge the patient a fee over and above the amount allowed by the plan. The patient who knows what legitimate and customary fees should be is becoming highly incensed at this exploitation and is asking the question, 'Who is the one insured and protected under these voluntary plans, the patient or the physician?'

"I think every physician, who may be tempted and yield to such practice, should constantly keep before him a few salient facts. Most of these voluntary plans have been sponsored by and are being operated under the supervision of the medical profession. The over-all success of the plans depends almost entirely upon the integrity and cooperation of the profession. They were

FORTY-THIRD ANNUAL MEETING

SOUTHERN MEDICAL ASSOCIATION

NOVEMBER 14-17, 1949

CINCINNATI

The twenty-one sections of the Southern Medical Association—Medicine, Surgery, Ophthalmology and Otolaryngology, Public Health, Medical Education and Hospital Training, Industrial Medicine and Surgery, Gastroenterology, Pediatrics, Urology, Obstetrics, Orthopedic and Traumatic Surgery, Radiology, Neurology and Psychiatry, Dermatology and Syphilology, Pathology, Gynecology, Allergy, Proctology, Anesthesiology, General Practice, and Physical Medicine—will have a total of thirty-two sessions, these being held at the Gibson, Sinton and Netherland Plaza Hotels on Tuesday, Wednesday and Thursday.

In addition to the Sections, there will be two General Clinical Sessions on Monday, one covering medicine and medical specialties and the other surgery and surgical specialties, the programs being arranged by the President, Dr. Oscar B. Hunter, Washington, D. C. These General Clinical Sessions will be held at the Netherland Plaza Hotel. There will be two independent associations holding their meetings conjointly with the Southern Medical Association.

Scientific exhibits will be presented wherein the latest research and work in the various medical specialties are graphically presented by outstanding physicians of the South. In the technical, or commercial exhibits, the physician will find the latest in medical equipment, pharmaceuticals, appliances and literature presented by business firms of the highest caliber. Only those products needed by the physician in his daily practice will be on display. Exhibits and registration at the Netherland Plaza Hotel.

The membership of the Southern Medical Association is drawn from the following states: Alabama, Arkansas, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia. The meeting is open also to eligible physicians from other states as guests.

The Campbell-Kenton County Medical Society of Northern Kentucky Will Be the Host Society

President, Dr. Robert L. Biltz, Newport. President-Elect, Dr. J. Gay VanDermark, Covington. Vice-President, Dr. Robert E. Reichert, Covington. Secretary, Dr. Raymond H. Weaver, Covington. Treasurer, Dr. John L. Cassidy, Covington. General Chairman, Dr. Arthur J. Schwertman, Covington. Vice-General Chairman, Dr. William R. Miner, Covington. Executive Committee, Dr. James A. Ryan,* Chairman, Covington, Dr. Charles W. Justice, Ludlow, and Dr. Oscar W. Frickman, Newport. Advisory Executive Committee, Dr. Clifford N. Heisel,** Chairman, Covington, Dr. Philip H. Dorger, Covington, and Dr. George R. Coe, Erlanger.

*Past President of the Southern Medical Association and Member of its Board of Trustees.
**Member of the Council of the Southern Medical Association representing Kentucky.

instituted in the beginning to do a job, in applying the insurance principle of spreading the cost of medical care over a large group. At the present they are our biggest weapon against federal attempts at compulsory health plans. The public by and large has been well pleased with the coverage they have received.

"It behooves the individual physician, who participates in and who is reimbursed by these plans, to use discretion and observe honesty lest he inadvertently contribute to a justifiable wave of resentment. As anesthesiologists, we must not allow ourselves to become a part of such practice and above all we must assume our responsibilities for the success of medicine's effort in behalf of the patient and against federalization of the practice of medicine."

There have been a few examples in Ohio of the abuses referred to by Dr. Stewart. However, they involve physicians of all classes. For that reason Dr. Stewart's warning applies to the medical profession as a whole, not just his own specialty.

Here in Ohio the Blue Cross plans and Ohio Medical Indemnity, Inc., the "Doctors' Plan" have won the respect and confidence of thousands of Ohioans. They will continue to win and to hold the respect and confidence of the people of Ohio and will continue to produce benefits of far-reaching importance to subscribers, hospitals and the medical profession, providing they have the complete cooperation of all three groups. They need especially the cooperation of hospitals and the medical profession which are bound only by the principles of honesty, justice and fair-play, not by contracts and legal phrases.

WAR HEALTH RECORD TESTIFIES FOR FREE MEDICAL SYSTEM

Despite adverse conditions during the war, the health of the people in the United States continued to improve, a recent publication by the Metropolitan Life Insurance Company points out.

"During this period millions of workers migrated to war industry centers, lived in crowded quarters, and worked long hours at arduous tasks," the report says. ". . . Concentration of troops in training camps increased the hazard of infection, and the assignment of our armed forces to various parts of the world exposed them to tropical diseases and to other maladies not found in our country.

"As against these unfavorable conditions were the epoch-making advances in medical science achieved in the decade (1936-1945)," the analysis continues.

This war health record is unprecedented in history and is another testimonial to our system of free enterprise in medicine. Perhaps the proponents of the compulsory health program can explain how it was achieved without their super-duper system.

DOCTORS AND POLITICS

Capital Comment, bulletin of the Democratic National Committee, commented in its August 6 issue about the squib in the July 27 *OSMAgram* regarding Senator Robert A. Taft.

The D. N. C. pep sheet observed: "The Ohio State Medical Association, which is dedicated to 'keeping politics out of the medical picture' wants its medicine men to jump into politics. The official newsletter says that doctors who want to see Senator Taft re-elected should 'join in on his campaign planning and activities.' It makes no recommendation to members who don't want Taft re-elected. The Association is also urging members to register and vote. That's a good prescription for the doctor's patients, especially those who want a pay-as-you-go national health insurance program."

True, the O. S. M. A. is dedicated to keeping politics out of the practice of medicine and medical services. By the same token, it is dedicated to encouraging its members to take an active part in political and governmental affairs. As citizens it is their obligation to work and vote for qualified candidates for public offices. As doctors it is their duty to work and vote for candidates who are not only qualified but who also subscribe to principles and policies which will insure good medical care for the people.

Capital Comment must have had its tongue in its cheek when it made the above observation. If sincere, it is the first time we ever heard of a political party committee discouraging doctors or anyone else from participating in political activities. Also, note the last sentence of the quote, which seems to leave no doubt where the committee stands on that issue.

FORETHOUGHT MAY GET YOUR TALK IN THE NEWSPAPER

Reporting of informal talks, such as physicians are called upon to make before luncheon clubs, are always a problem to the local newspaper. A little cooperative forethought on the part of the speaker is usually welcome by editors even in large cities.

Even a small city may have as many as a half dozen luncheon club meetings going on at the same time. It would be physically impossible for a newspaper to have reporters sit through each of these meetings.

Some editors send a reporter out in advance to contact the speaker and get a brief of his talk; then merely check afterward to make sure things went according to schedule. Others may contact the speaker afterward or ask one of the officers of the club to give a gist of the address.

Many a professional speaker comes to a meeting forearmed with a copy of his talk, or at least with a brief of his talk typewritten, which he

For mixed infections



New and Nonofficial Remedies • 1948 • states: "NITROFURAZONE.—Furacin . . . possessing bacteriostatic and bactericidal properties . . . effective in vitro and in vivo against a variety of gram negative and gram positive bacteria . . . is useful for topical application in the prophylaxis and treatment of superficial mixed infections common to contaminated wounds, burns, ulceration and certain diseases of the skin . . . Variant bacterial strains showing induced resistance to sulfathiazole, penicillin or streptomycin are as susceptible to nitrofurazone as their parent strains . . ." Furacin® brand of nitrofurazone, is available as Furacin Soluble Dressing (N.N.R.) and Furacin Solution (N.N.R.) containing 0.2 per cent Furacin. These preparations are indicated for topical application *in the prophylaxis or treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.*

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can pass on diplomatically to the reporter. The use of such "handouts" is frowned upon in some journalism schools, but in everyday newspaper work it has a definite place. To many a reporter with a full day's schedule, prepared notes on a talk are a godsend.

Obviously if a reporter wishes to sit in on your talk, so much the better. But no harm will be done by having a brief ready—just in case. If no reporter turns up, the speaker might suggest to one of the club officers that he pass on the notes to the newspaper.

If the talk is strictly scientific matter prepared for a medical meeting, the reporting may be difficult, but many a good newspaper article has been written from a scientific talk. The speaker might try his hands at interpreting the scientific talk in terms that the public will understand and appreciate.

On the other hand, if the talk is one of public relations, or is a medical talk given before laymen, it will lend itself well to a newspaper article.

Reports of doctors' talks in newspapers really build up the over-all public relations program. Most newspaper editors like to report talks of public interest. It's good public relations to meet them at least half way.

HUFFING AND PUFFING BUT LITTLE UNITY

We like the following subtle observation from the *Charlotte (N. C.) News*:

"Everybody lets every interest group fight its fight alone. The doctors fight socialized medicine, the real estate men fight public housing, each business or industry fights its own battle against government encroachment. But never together. 'Divide and conquer' is a marvelous strategy. It swallows its victims before they know they're bitten."

There is evidence of this situation here in Ohio.

Wouldn't now be a good time to correct it?

SENATOR DONNELL ALSO MARKED WITH AN "X"

We see by the 'papers that Labor's League for Political Education (A. F. of L.) has put the "x" on U. S. Senator Forrest C. Donnell, Missouri, as one of the senators, including Senator Taft, Ohio, who "must" be defeated in the 1950 election. Physicians will recall that Senator Donnell, as a member of the Senate Labor and Welfare Committee, made it mighty uncomfortable for witnesses in favor of compulsory sickness insurance bills when he put them through cross-examination.

It looks as if there will be a lively time in Missouri, as well as in Ohio, next year when the political campaigns get underway.

"WELFARE STATE" NOT ON THE WAY—IT'S HERE

Those who predict that we are headed for the "welfare state" haven't read available statistics too carefully. It's here already—to a degree.

Reliable estimates indicate that during the present fiscal year, starting last July 1, the Federal Government will pay out to individuals in welfare benefits, pensions, grants, etc., approximately $13,840,000,000 (it's billions, not millions). In 1940, these benefit payments totaled about $2,283,000,000.

During the same period, state and local governments will pay out of their own treasuries about $3,000,000,000 in welfare and public assistance benefits.

The same set of figures shows that Federal, state and local governments will pay out to business, including constructions of all kinds, roads, schools, etc., around $28,600,000,000, compared to about $6,500,000,000 in 1940.

The big question is: Will this trend continue; will it taper off?

The big problem is: What can be done to keep these expenditures from increasing; how to curtail them?

Some folks want to laugh off the warning that we are headed for "statism" in a jet plane. The figures quoted would indicate that it's far from a laughing matter as he who pays the piper calls the tune.

DIFFERENCE BETWEEN "O" AND "I"=$

Quote from the *Barnesville Enterprise*:

"GIVERNMENT"

"On the typewriter and on the linotype machine, the keys for the letters 'i' and 'o' are next to each other. And so it happened that the linotypist made a typographical error last week in spelling it 'Givernment' instead of 'Government.'

"On second thought, we are inclined to think that 'GIVErnment' is the proper way to spell it in these latter days."

Agreed!

ONE WAY TO GET THE FOLDERS READ

A physician in southern Ohio has advised us that he has tried a new stunt in getting literature on medical and health legislation to his patients and that it appears to be working well. He cleared his waiting room tables of all other literature, magazines, folders, etc., leaving the waiting patient no choice but to read the medical profession's story as told in the various pamphlets he received from the Columbus Office of the State Association. Try it in your office.



The incidence of mild protein deficiencies in children, predisposing toward infections and edema, is reported[1,2] much greater than generally realized. Infant and adolescent requirements—not only for tissue repair and maintenance, but also for growth—are much higher than in adulthood.[3] To insure adequate protein intake in infancy, DRYCO—Borden's high-protein infant food—is ideally suited as a basis for formula building. It furnishes *all the essential amino acids.* Its low fat content minimizes gastro-intestinal upsets due to fat intolerance, while its intermediate carbohydrate content lends itself for prescription with or without added carbohydrate. Quickly soluble in cold or warm water, DRYCO contains adequate vitamins A, B_1, B_2 and D, plus essential milk minerals.

References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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DRYCO *is made from spray-dried, pasteurized, superior quality whole milk and skim milk. Provides 2500 U.S.P. units vitamin A and 400 U.S.P. units vitamin D per reconstituted quart. Supplies 31½ calories per tablespoon. Available at all drug stores in 1 and 2½ lb. cans.*

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The "Custom Formula" High Protein Infant Food

Child Health Services . . .

As a Result of Survey of Medical Care of Children in State, Ohio Pediatricians Draw Certain Conclusions and Offer Recommendations

IN the April, May and June issues of *The Journal* appeared installments of a report covering a study of child health services and facilities in Ohio, made under the auspices of the American Academy of Pediatrics and the Ohio Chapter of that organization. Following is the final installment of the report which contains conclusions drawn from the survey by members of the Ohio committee which sponsored it together with their recommendations.

CONCLUSIONS AND RECOMMENDATIONS

These conclusions and recommendations are given with the thought in mind that they may be a stimulus to future planning. It is true that some of the deficiencies and inequalities have been overcome by the return from service of many doctors and dentists, but there are still many problems that need to be solved.

COMMUNITY PROMOTION

Good health is ordinarily found where there is a high standard of living: this embraces housing, sanitation, education, and income. It is in these fields that doctors should continue to take an active part in their community. They should continue to instigate, promote and guide any measures that would improve the general health of the community. Where the economic and cultural levels tend to be high the available facilities necessary to good health are more adequate. Good health is dependent upon good facilities and an awakened and interested community to provide them. Individual initiative and participation should be encouraged in these problems. Many of the inadequacies and inequalities that exist could be overcome or prevented if the people in a community knew what facilities are available and the need for good facilities.

PEDIATRIC TRAINING

More and adequately trained personnel are required. The medical schools in Ohio should encourage the Association of Medical Colleges to have those schools outside of the state that have only the preclinical courses to establish clinical courses.

Physicians should have more Pediatric training if a good child health program is to be developed. They should keep informed in what is being done in Pediatrics. A column devoted to Pediatrics in the *State Medical Journal* would be helpful in this respect. A Pediatric and speciality consultative service could be developed to help the physician in the rural area to give better service to the children under his care.

The shortage of dentists in the state would suggest the need of another Dental School. This could also provide more dental hygienists and encourage their use.

The shortage of nurses indicates the need for awakening in young women a desire to enter the nursing profession. There are many opportunities for service in the various branches of the profession that should be made attractive to eligible candidates.

COORDINATION OF FACILITIES

Community health services for children are adequate in only a few communities of the state. Child health conferences should be promoted, especially in the rural areas. The same can be said of School Health Services. It is only in the larger cities that there is a school health program and in many of these it is inadequate.

It would appear that the services for crippled children would need to be increased, as some areas have little service for any type crippled or handicapped child. However, it may be that what is needed is better coordination of facilities available for the spastic, cardiac and the epileptic child and in some areas for any type of crippled child such as congenital deformities and bone tuberculosis.

The infant mortality rate has declined steadily, but there is still need for a coordinated program for the care of the newborn and especially of the premature. A plan should be organized to care for premature infants from outlying areas in hospitals that have facilities for this type of service. The infants could be transported soon after birth in especially adapted conveyances. The care of the fetus and newborn has been given much thought and much can be accomplished in further reducing maternal and infant mortality.

Rheumatic fever is fought in the larger cities, but there is no program on a state-wide basis. Immunization likewise is carried out generally in the urban centers, but much needs to be done in the isolated areas.

HOSPITAL FACILITIES

The shortage of hospital beds and hospital facilities exists over the entire state. The Hill-Burton Bill is a means of obtaining relief. The high cost of construction and maintenance apparently has been a deterrent in the building of new hospitals. However, communities ought to recognize their responsibility in building and

maintaining a hospital. It is the consensus of opinion that physicians will migrate to those communities where hospital beds and facilities are available. New hospitals to be built should provide accommodations for communicable diseases, especially poliomyelitis.

The hospitals in the outlying areas should have an affiliation with a larger medical center for consultation and laboratory service. An arrangement might be made for a rotation of interns or residents between them.

Where it would not be practical to have a hospital, ambulatory facilities might be planned to furnish portable X-ray, laboratory services, or other hospital facilities such as the giving of special medication, subcutaneous or intravenous fluids or blood transfusions.

INFORMATION ON FACILITIES

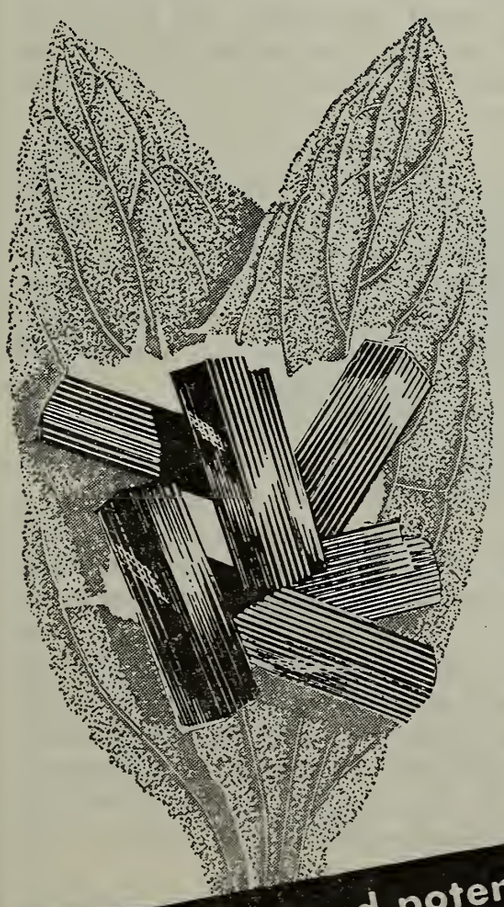
Many of the inequalities and inadequacies could be prevented or overcome if the people realized the need for and the availability of health facilities. It is assumed that people living in the adjacent counties avail themselves of the facilities in the metropolitan areas, but there is some evidence to indicate that this is not true. The people should be informed of what is available for them through an educational program to be used by the P. T. A., American Legion, Farm Organizations, Labor Organizations, Infantile Paralysis Chapters, Anti-Tuberculosis Chapters and all organizations interested in children.

LONG-TERM PROGRAM

The physicians and dentists of the state who are familiar with the need for improved facilities for good child health in several sections of the state should formulate a long-term program. The members of the Ohio Chapter of the American Academy of Pediatrics could be helpful since the American Academy of Pediatrics has standing committees on Immunization, School Health Service and Care of Fetus and Newborn and other committees pertaining to child health. The program should include the care of the premature and newborn; Rheumatic Fever; Immunization; Crippled Children, especially the poliomyelitic, spastic, epileptic; ways and means of making facilities available to doctors in outlying communities, especially consultative service or portable hospital service. From this program proposals could be drawn from time to time and presented to a Children's Council or an advisory committee on Child Health.

ADVISORY COMMITTEE

A Children's Council or an advisory committee on Child Health should be organized by the State Medical Association for the purpose of studying and executing the proposals for the improvement of child health submitted to it.



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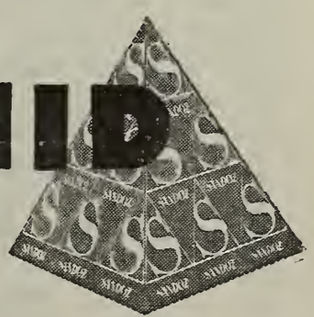
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Medical Reserve Corps Program . . .

Army's Training Program for Civilian Physicians Is Efficient and Practical, Participating Doctors Assert; Snafu Conspicuously Absent

THE Medical Reserve Officer who did not take advantage of the two-week tour of Active Duty at one of the Army teaching installations missed an opportunity to improve himself professionally. The physician with World War II experience was apt to look upon summer training, as offered by regular Army establishments, with misgivings as to its suitability in his field of endeavor.

Let us give you a composite picture of this summer's training as conducted at Valley Forge General Hospital, 25 miles west of Philadelphia. This is not our opinion alone, but reflects the reactions of all of the Medical Reserve Officers who attended.

The most unusual of all was our introduction; the usual "Snafu" was absent. They were actually expecting us and were prepared in every detail. By agreement with the Surgeon General's Office no prescribed hours of lectures, drills, or exercises were scheduled. As mature and apparently intelligent medical people we were put on our own and encouraged to look into any part of the work conducted in this large 1850-bed General Hospital, with a present census of 1350 patients, whose average stay is approximately 22 days.

ONE OF 10 CENTERS

This institution is one of ten set aside by the United States Army for graduate professional education. In addition to the well-trained permanent staff there are 15 internes and 26 residents. There is a staff of 70 consultants from Philadelphia and Baltimore, all of whom are certified by their various specialty boards. To read this list is much like reading a "Who's Who" in medicine and surgery.

These gentleman are not only on call, but have scheduled rounds, operations, conferences, consultations and teaching hours. We were given a schedule of these events for the month of August, which was broken down into daily hours and it was up to the individual Medical Reserve Officer to choose that which he thought would interest him most. He was encouraged to enter into all discussions; to give his impressions, opinions, and experiences, and in many cases, he was asked to assist in the management and handling of the case.

AMPLE FACILITIES

At Valley Forge General Hospital there are some 342 beds in the orthopedic service, 171 beds in the plastic surgery section, 100 beds in neuropsychiatric section; and this is the Army Center for the study of liver metabolism and diseases of the liver.

There are also the various large departments of general medicine, 610 beds in general surgery, obstetrics and gynecology, and here is located one of the very few centers for the custom manufacture of plastic eyes. Since Valley Forge receives many patients from overseas, there is a very well equipped and staffed medical laboratory. Located there are excellent shops for the custom manufacture of prosthetic appliances, Maxilo facial reconstruction and all types of orthopedic devices. There are, of course, the Occupational Therapy and arts and skills shops for the rehabilitation of the handicapped patient.

OPPORTUNITIES UNLIMITED

For the general practitioner there is an unsurpassed opportunity for him to better himself professionally in all fields of medicine or any branch of his choice. For the specialist there is the additional opportunity to visit clinics in Philadelphia and to meet and become better acquainted with the outstanding men in his own field. There would be no better place for review for the man who is preparing for his specialty board examinations. This type of training is not peculiar to this hospital, but is being conducted in the same manner at similar Army hospitals throughout the country.

It is evident to us that the Regular Army is doing all in its power to build Reserve Units, not on paper alone as in the past, but to assist in the organization and training of these Reserve Units

The accompanying article was written in the interest of the Medical Corps of the Organized Reserve and the medical profession by Dr. Edward T. Kirkendall of Columbus and two other civilian physicians who attended the summer training course at Valley Forge General Hospital. Dr. Kirkendall holds the rank of Brigadier General in the Organized Reserve Corps and commands the 806th Hospital Center, a Reserve unit. Collaborating with him were Dr. William L. Halton, Lt. Colonel, and Dr. John H. Kilmer, Major, both Medical Reserve officers of the 345th General Hospital unit, Martinsburg, W. Va.

so that they may fulfill their mission in the general scheme of our National Defense, and further the professional knowledge of the individual Medical Reserve Officer for his civilian pursuits and possible integration into the Armed Forces in case of need.

We strongly recommend that all physicians who feel that they are physically and mentally qualified, and whether or not they have had previous military experience, avail themselves of a commission in the Organized Reserves and such duty and training as the Army offers.

Course on Urinary Tract Disorders

On November 17, 18, and 19, the Frank E. Bunts Institute and the Cleveland Clinic will present a continuation course for physicians on "Medical and Surgical Disorders of the Urinary Tract." Dr. Herman L. Kretschmer of Chicago will give the evening address November 17 on "Clinical Significance of Hematuria." The other out-of-town guest speaker will be Dr. Louis Leiter of New York, who will speak on "Uremia" Saturday morning, November 19, and who will take part in the panel discussion closing the course.

Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

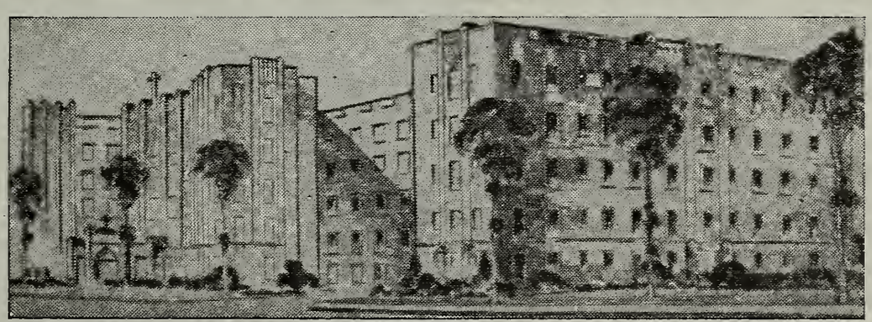
Wants Data on Twins in Study of Heredity In Peptic Ulcer

The following request was received by *The Journal* from Dr. A. C. Ivy, Department of Clinical Science, University of Illinois, Ohio physicians who have material on cases which they believe would be of interest to Dr. Ivy should send it to him in care of 1853 West Polk Street, Chicago 12.

"The study of twins is of great value in providing information concerning the respective importance of hereditary predisposition and environmental influences in disease in man. The results of the use of this method have shown a hereditary predisposition to tuberculosis, diabetes, and tumor formation, and a high, medium or low intelligence quotient.

"There is some *a priori* evidence showing an hereditary predisposition for peptic ulcer. Only six cases of the occurrence of peptic ulcer in the one or both of mono- or dizygous twins have been reported in the readily accessible literature. Since twins are born in 1 of 86 births and identical twins in 1 of 344 births and the general incidence of ulcer is from 5 to 10 per cent there should be plenty of material available.

"I should like to ask physicians to cooperate in assemblying such material by sending me cases in which (1) one or both twins develop peptic ulcer, (2) the site of the ulcer, (3) the age of onset of ulcer, (4) the type of twins (monovular or diovular), (5) the sex of the twins, (6) the date of birth of the twins, and (7) the number and age of the brothers and sisters and the absence or presence of ulcer in each."



The John N. Norton Memorial Infirmary announces the opening of a complete unit for the Treatment of Alcoholism

A new 125 bed addition financed by public subscription, supplemented by Federal and State grants, includes a 20 bed unit for treatment of alcoholism. A five-day period of treatment, which has proved to have the most permanent results, will be given under the direction of an internist especially prepared for this service. All other services of the hospital and consultation from any division of the Medical Staff are available if required; particularly consultation from the newly organized Psychiatric Department, which is being operated on a post-graduate teaching basis in affiliation with the University of Louisville School of Medicine. An all inclusive fee will be charged for the standard five-day period. There are separated facilities for the care of women . . . For full information, write or telephone

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Income Tax Interpretation . . .

Entertainment Expenses May Be Ruled Out Entirely From Deductible Items as Revenue Department Issues New Fiat From National Level

THE following article which appeared in the July issue of the *Bulletin of the Columbus Academy of Medicine* gives some interesting slants on new interpretations of the Federal income tax regulations. It was written by Mr. Stanley R. Mauck, executive director of the Columbus Bureau of Medical Economics, and is of interest to all physicians.

According to information brought to the attention of the Professional Management Department of the Medical Bureau, doctors may be faced with disappointing new developments in the field of income tax returns.

In the past it has been considered perfectly legitimate to classify reasonable and supportable entertainment expense as deductible items on income tax returns. Items of this character have always been carefully scrutinized by the Internal Revenue Department, but they have usually been allowed if they were reasonable in amount and supported by proper evidence when returns have been reviewed by field inspectors.

MAY BE RETROACTIVE

It now appears, however, on the basis of several instances brought to the attention of the Medical Bureau, that new regulations have been issued from Washington which indicate that entertainment expense is to be ruled out entirely. It even appears that an effort will be made to apply these regulations as an *ex post facto* law by making them applicable to returns prior to 1949.

Regardless of the justice or injustice of the new regulations to be applied during the current year, it seems eminently unfair to apply these regulations to the years prior to 1949. The unfairness of the retroactive feature of this new ruling lies in the fact that only the doctors who have their tax returns checked will be penalized. Deductions by those not checked will thus be allowed to stand.

It may be a little early to assess the true significance of this new ruling, as confusion in interpretation seems to exist, based on several cases known to the Bureau. However, there is little comfort for the professional man in the recent activities of the Internal Revenue Department. It is therefore more important than ever before that the books and records in his office be maintained accuately and systematically so that all deductions for professional expense, of whatever character, may be properly supported in the event that his return is selected for review.

As the end of another "tax year" approaches, *The Journal* publishes the accompanying article with the hope it will help some physicians arrive at their taxable incomes. Another article on this subject is being prepared for the November issue. *The Journal* has scheduled for the December issue its annual roundup on aids for physicians in filing their tax forms.

The law does not require any uniform method of accounting to be applied to all classes of taxpayers. Flexibility in systems are permitted to suit the purpose of the individual office. The method employed, however, must clearly reflect the true picture of the operations, and records must be maintained which will enable proper and correct income tax returns to be made.

BURDEN OF PROOF

The taxpayer must be able to prove by books and records that amounts expended were both necessary and ordinary expenses, and essential to the business of the office. The burden of proof is always on the taxpayer. It is, therefore, important to keep all receipts, bills, correspondence and cancelled checks which support the figures on your tax returns.

The Bureau emphasizes that it is not necessary to establish a complicated system of bookkeeping. Some simple system should be used which provides a permanent record of daily practice, receipts and disbursements. The records should provide for distribution of expenses under such classification as drugs, rents, salaries, utilities, etc. A correct control should also be maintained for all capital items such as furniture, equipment, and any supplies having useful life of more than one year, so that annual depreciation may be accurately computed. Salary records must be kept which show the gross amount credited, together with deductions for old age benefits (Social Security), federal withholding, city withholding, and the net amount paid the employee.

Without adequate information on file, the Revenue Department is likely to estimate income by arbitrary methods, such as percentages, bank deposits and withdrawals, or on a net worth basis, which may prove costly if the doctor cannot disprove the inspector's estimate.

Death *and taxes* are still with the doctor!

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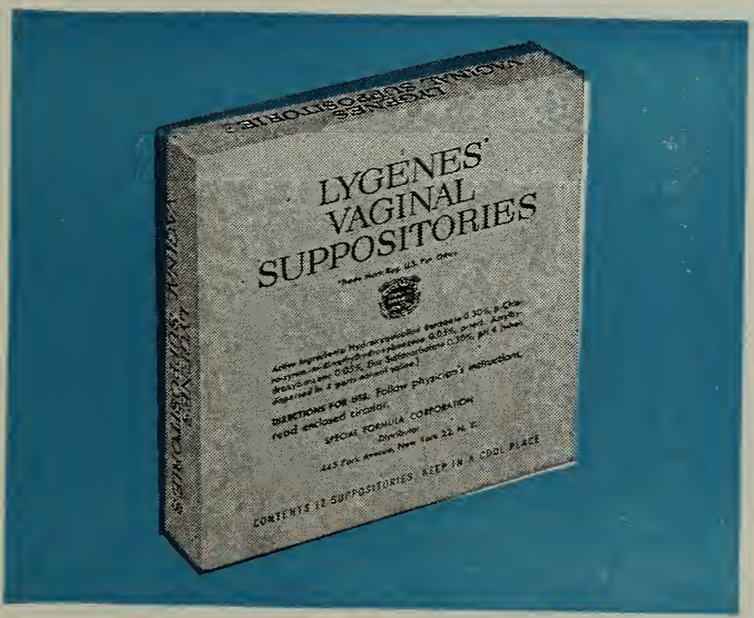
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*Eastman, N. J., Dept. of Obstetrics, Johns Hopkins University and Hospital, Baltimore; Seibels, R. E., Memorial Laboratory, Columbia, S. C.; J.A.M.A., 139:16-19 (Jan. 1) 1949.

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"These (National Health plan) and many other minor services, promise the Briton full security. Yet today, actually he is most insecure. For the all-giving British government is going broke. There can be no security for people when the government is insecure."—*E. T. Leech, Editor, The Pittsburgh Press, in Scripps-Howard series, entitled UTOPIA ON THE ROCKS—BRITISH SOCIALISM IN ACTION.*

* * *

"The popular selling term today for prepaid sickness care is 'health insurance.' However, none of the compulsory plans which I have seen qualify as to either of the words. These plans do not provide good health nor are they insurance. Good health comes from such things as good public sanitation, personal hygiene, balanced diet, good housing, adequate clothing, prudent exercise, proper working conditions, and good personal habits. It might even require a little self-discipline."—*Robert A. Hornby, vice-president, Pacific Lighting Corporation, San Francisco.*

* * *

"Every effort is made to sidestep bed requests from elderly or chronic patients who may tie up those beds for extended periods. The theory is: 'They have lived their lives; let the beds go to the younger people and to emergency cases.' "—*William Alan Richardson, editor of Medical Economics, recently returned from an on-the-spot study of the British system.*

* * *

"With government mass medicine, the misapplications and abuses of the benefits, the incompetence at the service level, the crocodile tears over the hypochondriac, the general fuzz-buzzing of the records, and the deterioration in medical service, would be an all-time high or low, depending upon whether you were viewing the failure quantitatively or qualitatively."—*Robert A. Hornby, vice-president, Pacific Lighting Corporation, San Francisco.*

"Whether these newest eras are right or wrong, 'security,' which eliminates the risks in life, also kills the joy that lies in competition, in individual adventure, new undertakings and new achievements."—*Herbert Hoover.*

* * *

"Nobody else on earth pays such heavy taxes. Forty per cent of the whole British income goes for taxes . . .

"With what is left after taxes, there is little the Briton can buy or own. Such things as buying a home or an auto or any of our standard household appliances are out of the realm of possibility for the average worker or middleclass white-collar man."—*E. T. Leech, Editor, The Pittsburgh Press, in Scripps-Howard series, entitled UTOPIA ON THE ROCKS—BRITISH SOCIALISM IN ACTION.*

* * *

"It is now a year since the new Health Act first came into operation, and already its more glaring defects and shortcomings, both professional and economic, must have come to light. That the Act would be exploited was inevitable in view of its framework, but the extent to which it can be exploited must by now be exposed."—*R. G. Blair in a letter to the British Medical Journal.*

* * *

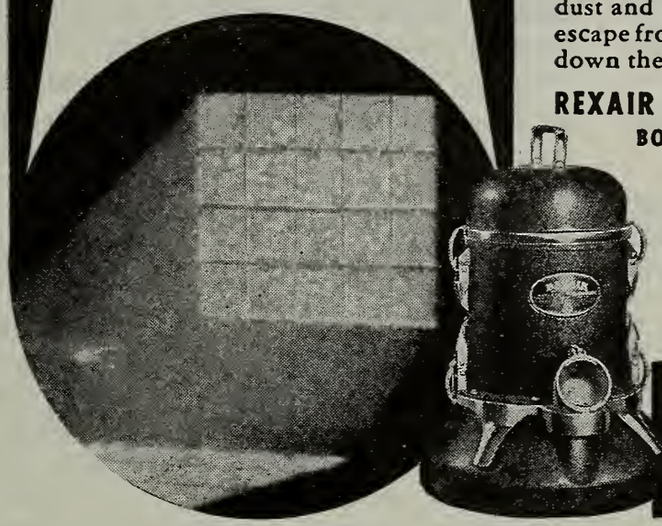
"Mr. E. W. Maples, LL. D., has written an interesting pamphlet on 'Social Security Services in New Zealand' after an eight weeks' visit to the country. He compares the health services there with those in Britain, and emphasizes that the New Zealand method of paying doctors a fee for each service should not be adopted in England. He considers that, as in New Zealand so in England, the patient-pressure on the doctor, which can be satisfied only too easily by prescribing drugs, is likely to increase materially."—*British Medical Journal.*

* * *

"After five weeks in Great Britain, we came home with new reverence for the faith in mankind that created America. It is our conclusion that there is no hope, peace of mind, or real security for anyone in the belief that 'The State is my Shepherd, I shall not want.' "—*John W. McPherrin, Editor of American Druggist.*

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Sixth Councilor District To Present Lahey Clinic Speakers Nov. 30

The Sixth Councilor District Post Graduate Assembly will present speakers from the Lahey Clinic of Boston, Mass., on Wednesday, November 30, at the Pick-Ohio Hotel, Youngstown.

The program is as follows

9:00- 9:30 A. M.—Registration

9:30-11:30—Discussion of Lesions of the Stomach and Duodenum

(a) Medical Approach and Management—Dr. Sara M. Jordan

(b) Surgical Therapy—Dr. Samuel F. Marshall

11:30-12:00—"The Painful Shoulder with Particular Reference to Subacromial Bursitis"—Dr. James W. Toumey

1:30- 2:00 P. M.—Panel: "Complications of Chronic Ulcerative Colitis"
Dr. Sara M. Jordan
Dr. Samuel F. Marshall

2:00- 2:45—"Diagnosis and Management of Bronchiectasis," Dr. Carlton R. Souders

2:45- 3:30—"Cicatrizing Enteritis"—Dr. Samuel F. Marshall

3:30- 3:40—Intermission

3:40- 4:25—Pulmonary Carcinoma—Clinical Features"—Dr. Carlton R. Souders

4:30- 5:00—Panel: "Combined Medical and Surgical Problems"
Dr. Sara M. Jordan
Dr. Carlton R. Souders
Dr. Samuel F. Marshall
Dr. James W. Toumey

5:00- 5:40—"Diagnosis and Treatment of Low Back and Sciatic Pain," Dr. James W. Toumey

8:00- 9:00—"Diagnosis and Management of Functional Disorders of the Digestive Tract"—Dr. Sara M. Jordan

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The Federal Security Administration's Food and Drug Administration is making seizure of "Syrup of Urethane," a cough syrup manufactured by Marvin R. Thompson, Inc., Stamford, Conn. Physicians, pharmacists and consumers are warned that the administration of Urethane in the quantity recommended on the label may cause a dangerous lowering of the white blood cell count, according to the announcement.

Fifty-five grants totaling $138,726, in support of medical research, have been awarded during the first half of 1949 by Smith, Kline & French Laboratories, of Philadelphia.

Columbus Regional Blood Bank Ranks High in National Scale

During the first six months operation of the Red Cross Regional Blood Center, 30 E. Town St., Columbus, a total of 10,367 pints of blood have been collected both at the Center and from visits of the bloodmobile in 26 surrounding counties participating in the program.

The report of Blood Center operations from the date of opening, December 7, 1948, to June 1, 1949, a six-month period, is made public by Anthony L. Schmieg, center director.

Of the amount collected, 5,194 pints of blood have been distributed to hospitals in Franklin County, the remainder being used to meet the needs of hospitals in the participating counties. Besides making regular weekly deliveries of blood to local hospitals, all emergencies have been met both here and in the region serviced by the Blood Center.

All of the needs in eleven of the seventeen hospitals in Franklin County have been met, and the Center has supplemented the existing blood banks in the remaining six hospitals. For the past four months 78 per cent of all blood needs of the county have been met, stated Schmieg.

Although the Columbus Regional Blood Center was the 18th center in the American Red Cross National Blood Program to be opened, it ranks in the top five in the country in pints of blood collected.

During the month of April it was in fourth place with only centers at Rochester, N. Y., Washington, D. C., Los Angeles, California, and the Massachusetts State Blood Program producing more blood. All of these centers were opened months prior to the Columbus Center.

Emergency deliveries of blood have been made within the state and on one occasion outside the state, using the quickest means of transportation available—commercial and private planes, bus service and on three occasions the State Highway Patrol rushed blood to Celina, Kenton and Bellefontaine hospitals. Volunteer motor service drivers have made emergency deliveries locally and to other counties, even in the middle of the night.

"Local hospitals have been more than cooperative with us," said Schmieg. "They have been understanding when we have not been able to furnish all the blood they have asked for. Many of them are now sending donors to our Center for patients in their hospitals needing blood."

He pointed out that the continued cooperation of the public and the hospitals will mean the success of the Blood Program here. It will mean eventually that Red Cross blood will be available to all who need it, when it is needed and in the amount needed.

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In Memoriam . . .

Lewis Theodore Arthur, M. D., Covington, Ky.; Medical College of Ohio, Cincinnati, 1904; aged 72; died September 8; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1948. Dr. Arthur practiced in Montezuma and Celina before moving to Kentucky in 1923. Surviving are his widow, two sons, a daughter, a brother and two sisters.

William Henry Beery, M. D., Lima; Hahnemann Medical College and Hospital of Philadelphia, 1907; aged 74; died September 4; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Academy of Medicine of Lima and Allen County, 1943. Dr. Beery had been practicing his profession in Lima for approximately 35 years. He was a member of the Presbyterian Church and the Lions Club. Surviving are his widow, two daughters and three sons, including Dr. Walter C. Beery, with whom he was affiliated professionally, and Dr. Emerson B. Beery of Cleveland.

Benjamn Oscar Burkey, M. D., Baltic; University of Wooster Medical Department, 1911; aged 64; died August 21; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Tuscarawas County Medical Society, 1945. Dr. Burkey had practiced medicine in Baltic and vicinity for 37 years. He was a member of the Masonic Lodge. Surviving are his widow, two sons, one daughter and one foster daughter.

Arthur Maitland Chatham, M. D., Cleveland; Western Reserve University School of Medicine, 1905; aged 71; died August 10; member of the Ohio State Medical Association and a Fellow of the American Medical Association. A native of England, Dr. Chatham came to this country at the age of 12. He had practiced medicine in Cleveland for approximately 36 years. He was a member of the Masonc Lodge, the Kiwanis Club, the Presbyterian Church and was active in Boy Scout work. Surviving are his widow, two sons, a daughter, three brothers and a sister.

Meyer Hantman, M. D., Cleveland; Western Reserve University School of Medicine, 1931; aged 41; died August 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Hantman had practiced in Cleveland since the completion of his medical education. He was a veteran of World War II and was a member of Phi Beta Kappa fraternity. Surviving are his widow, a son, his mother, four sisters and two brothers, one of whom is Dr. Samuel Hantman, also of Cleveland.

Arthur Huston, Jr., M. D., Dormont, Pa.; Hahnemann Medical College and Hospital of Philadelphia, 1931; aged 42; died August 31; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1948; secretary-treasurer of the Tuscarawas County Medical Society in 1934. Dr. Huston practiced in Uhrichsville before moving to Pennsylvania only recently. Surviving are his widow, two children, his parents, Dr. and Mrs. Arthur Huston, Sr., of Pittsburgh, a brother and a sister.

Kromer Columbus Ice, M. D., LaHabra, Calif.; St. Louis College of Physicians and Surgeons, 1903; aged 73; died August 27; former member of the Ohio State Medical Association and the American Medical Association through 1929. Dr. Ice practiced in West Virginia and Ohio before retiring to California several years ago. Surviving are his widow, a daughter and a son.

Byron Henry Jacob, M. D., Ravenna; Trinity Medical College, Toronto, Canada, 1895; aged 83; died September 1; Dr. Jacob practiced in Kent from 1902 until 1919 when he moved to Florida. He returned to Ohio about a year ago. Surviving are a son, a daughter and two sisters.

John Francis Rudolph, M. D., Warren; Western Reserve University School of Medicine, 1903; aged 77; died August 22; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1945; president of the Trumbull County Medical Society in 1929. Dr. Rudolph had practiced in Warren until his retirement in 1942. He was a veteran of World War I, and was a member of the American Legion, the Masonic Lodge, Phi Rho Sigma and the Odd Fellows. Surviving are his widow, a son, Dr. John F. Rudolph, Jr., of Cleveland, and a sister.

Edwin Jay Wilkinson, M. D., Toledo; Toledo Medical College, 1902; aged 70; died August 29; former member of the Ohio State Medical Association and the American Medical Association through 1931. Dr. Wilkinson was in active practice in Toledo from the completion of his medical education until his death. Surviving are his widow and a brother.

Cyrus Edward Yeagle, M. D., Toledo; Toledo Medical College, 1903; aged 77; died September 4; former member of the Ohio State Medical Association and the American Medical Association through 1924. Dr. Yeagle had practiced in Toledo for more than 45 years. Surviving are two daughters, a son, two brothers and a sister.

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Do You Know? . . .

Membership in the Ohio State Medical Association on September 19 was 7,363, the largest in the Association's history. There were 7,331 members on December 31, 1948.

* * *

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, participated in a panel discussion on "Bulletins" at the recent annual Fall conference of the Ohio Association of Trade Executives.

* * *

Guest speakers at the centennial annual session of the Indiana State Medical Association, Sept. 26-29, at Indianapolis included Dr. Louis G. Herrmann, Cincinnati, who spoke on "Surgery of Large Arteries," and Dr. Rolland J. Whitacre, Cleveland, who discussed "Prevention Preferred in the Operating Room."

* * *

The following Ohioans were among the guest speakers at the annual session of the Michigan State Medical Society, Sept. 21-23, at Grand Rapids: Dr. Warren E. Wheeler, Columbus, "Pulmonary Infections with Histoplasma in Children"; Dr. Robert M. Zollinger, Columbus, "Indications for Surgery in Gallbladder Disease"; Dr. U. V. Portmann, Cleveland, "Cancer of the Breast."

* * *

Announcement was made from Washington that Dr. Richard L. Meiling has been nominated by the President and approved by the Senate for the rank of Brigadier General in the U. S. Air Force Reserve. Dr. Meiling of Columbus is serving in a civilian capacity as deputy director of the National Military Establishment's Medical Service Division and is scheduled to be elevated to full directorship on October 1.

* * *

Dr. and Mrs. Joseph L. Fetterman, Cleveland, attended the Fourth International Neurological Congress in Paris, France, September 5-10. Dr. Fetterman addressed the Congress on the subject, "The Role of Methyl-Phenyl-Ethyl-Hydantoin (Mesantoin) in the Treatment of Epilepsy."

* * *

Three Cleveland physicians, Dr. Claude S. Beck, Dr. Richard P. Bell and Dr. E. D. Saunders, were instrumental in establishing a Pan-American Doctors' Club, to achieve a closer understanding among the physicians of America. The club has purchased a meeting place in the Sierra Madre Mountains near Mexico City which they fondly refer to as a "Shangri-La."

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

CLINTON

A business meeting of the Clinton County Medical Society was held on August 2, in Wilmington, at which the fall program of the society was discussed.

At the September 6 meeting, Dr. Marvin F. Stevens of Cincinnati spoke on the subject, "Undulant Fever." Dr. E. Dalton Peelle resigned as president of the Society and has left to take a special course in ophthalmology at Harvard University.

HIGHLAND

Dr. Warren E. Wheeler, Ohio State University College of Medicine, spoke on "Care of the Premature Infant" at the September 7 meeting of the Highland County Medical Society.

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

DARKE

The Annual Fall Meeting of the Darke County Medical Society was held at the Greenville Country Club September 20. Wives of members and special guests were present to hear an address by Mr. Glen Massman, executive secretary of the Foreman's Club of Dayton.

MIAMI

Congressman W. M. McCullough of Piqua, who was home for a short period from Washington, addressed the Miami County Medical Society at its September 9 meeting on the subject "Happenings in Washington and the 81st Congress." The event was a dinner meeting at the Memorial Hospital in Piqua.

MONTGOMERY

The 100th Anniversary of the Montgomery County Medical Society was celebrated with a Founders' Day dinner on September 13 in the Biltmore Hotel, Dayton.

Dr. A. C. Ivy, University of Illinois, who served as a medical advisor at the Nurnberg trials in Germany, was guest speaker and talked on "Medical Ethics, Democracy and Medical Care."

Among honored guests was Dr. Elmer L. Henderson, President-Elect and Chairman of the Board of Trustees of the American Medical Association.

A key event of the meeting was presentation by Dr. M. D. Prugh, Councilor of the Second District of the Ohio State Medical Association, of a number of 50-year pins to doctors who have completed a half century of practice.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

Dr. Cornelius P. Rhoads, director of Memorial Hospital and the Sloan-Kettering Institute for Cancer Research, New York City, will be guest speaker for the Inter-Hospital Postgraduate Lecture Series presented by the Medical Advancement Trust of the Maumee Valley Hospital, and sponsored by the Academy of Medicine of Toledo and Lucas County. The series is scheduled for Thursday and Friday, October 6 and 7, with late afternoon and evening lectures on each day and a noon lecture on Friday. Subjects to be discussed are "Hormone Metabolism in Cancer," "Hormone Treatment in Cancer," "Radical Surgery in Cancer," 'Chemotherapy in Cancer," and "Progress in Cancer Research."

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

CUYAHOGA

"A Symposium on the Treatment of Heart Disease" was the program of the September 16



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meeting of the Cleveland Academy of Medicine, with Dr. A. C. Ernstene as moderator.

Speakers and their topics were the following: Dr. John W. Martin, "Congestive Heart Failure"; Dr. A. D. Nichol, "Angina Pectoris"; Dr. R. W. Scott, "Acute Myocardial Infarction"; and Dr. Harold Feil, "Disburbances of Cardiac Rhythm."

The Board of Directors of the Cleveland Academy of Medicine at its meeting on June 14 elected Dr. Howard T. Karsner and Dr. Frank P. Corrigan as honorary members of the Academy.

Dr. Karsner is the retiring professor of pathology at Western Reserve University, and Dr. Frank P. Corrigan is a United States Delegate to the United Nations. Both of these physicians were given honorary degrees at the recent commencement of Western Reserve University.

Dr. Karsner, who will be an advisor to the United States Navy with offices in Washington, has contributed greatly to the development of the specialty of pathology not only in Cleveland but in the entire nation. As professor of pathology, he has been director of the Institute of Pathology of Western Reserve University and active in the development of his specialty in many other hospitals in Cleveland.

Dr. Corrigan, who since the late thirties, has served the United States Government as Minister to Salvadore and Ambassador to Venezuela, is now delegate to the United Nations, in addition to his present assignment. A surgeon at St. Alexis Hospital, he was director of that department before leaving Cleveland.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

PORTAGE

"Some Obstetrical Problems," was the topic of a talk by Dr. Alven M. Weil of Akron at the September 8 meeting of the Portage County Medical Society at the Robinson Memorial Hospital in Kent.

STARK

Representatives of the Stark County Medical Society met with county commissioners and several members of the board of trustees of Molly Stark Tuberculosis Sanitorium in August to discuss closer cooperation between local physicians and the hospital staff.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Members of the Bellaire City Hospital staff conducted the program at the September 15 meeting of the Belmont County Medical Society.

TUSCARAWAS

The Tuscarawas County Medical Society went on record as favoring the proposed setting up of

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an orthopedic clinic at the county health department. Dr. C. Raymond Crawley, Dover, was appointed to head a program to replenish the blood bank at Union Hospital.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

Guest speaker at the September 1 meeting of the Guernsey County Medical Society at the Hotel Berwick, Cambridge, was Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Ohio State Medical Association. Topics and plans for the Eighth District Post Graduate meeting to be held in Cambridge October 6 were discussed.

It was reported that the City Council has authorized a contract to be drawn up for further consideration on the merging of the health departments of city and county.

Dr. James Toland was appointed to see that there is a doctor to set on the bench at all home football games. Dr. William L. Denny, president, was in charge of the meeting.

At the September 15 meeting of the Society, the program was in charge of Dr. H. R. Neeland of Cambridge who demonstrated techniques of electric shock treatments. Dr. A. T. Hopwood, superintendent of the Cambridge State Hospital, discussed various methods of admitting patients with particular reference to new simpler methods recently adopted by the Ohio Legislature. Numerous patients were presented to show results of treatment by various methods.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

SCIOTO

"Surgical Advances of the Past 12 Months" was the topic of a talk by Dr. R. W. Lewis of Portsmouth at the September 12 meeting of the Hempstead Academy of Medicine.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

Dr. E. O. Swartz of Cincinnati, President-Elect of the Ohio State Medical Association, spoke before the September 13 meeting of the Lorain County Medical Society on the subject, "The Doctor Looks at Public Relations."

Application forms are now available to those veterans who wish to claim their G. I. insurance dividend to be distributed by Veterans Administration. Payment of the dividend is not automatic—application on the official form must be made. These forms are available at post offices, V. A. offices and veterans' organizations.

Urology Awards Offered

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Washington, D. C., May 29-June 1, 1950. For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, N. J. Essays must be in his hands before February 20, 1950.

Nearly $6,000,000 was contributed through the 1949 Easter Seal campaign for service to the nation's handicapped, according to Gerald M. Ungaro, of Chicago, treasurer of the National Society for Crippled Children and Adults. Ungaro said that on the basis of returns received to date, the 1949 drive would result in about a one-half million dollar increase over 1948 returns.

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Buckeye News Notes . . .

Amherst—Dr. Carlisle H. Snell was principal speaker at a meeting of the local Rotary Club.

Bellefontaine—Dr. A. J. McCracken, attended the American Legion National Convention in Philadelphia. It was the 26th time that he was present at the national event.

Columbus—Dr. Jonathan Forman, Editor of *The Journal*, took a prominent part in the Ninth Annual Meeting of the Friends of the Land, of which he is vice-president. The meeting was held in Pittsburgh, September 8-9.

Columbus—Dr. Benjamin C. Houghton, Ohio State University College of Medicine, spoke on the subject, "The Industrial Nurse as a Health Educator," at a meeting of industrial nurses.

Celina—Dr. George H. McIlroy is heading the Red Cross Blood Committee for Mercer County.

East Liverpool—Dr. Robert M. Dunlap is the new health commissioner of Columbiana County.

Hillsboro—Dr. J. Martin Byers of Greenfield spoke on the topic of the "School Health Programs" at a meeting of the Highland County Health Council.

Lorain—Dr. William S. Baldwin, practicing physician in Lorain for many years, has accepted a position with the Ohio Industrial Commission in Columbus.

Logan—Dr. Harve M. Clodfelter, Tenth District Councilor of the Ohio State Medical Association, addressed the Logan Rotary Club on the subject of "Socialized Medicine." Dr. Owen F. Yaw of Logan was program chairman.

Massillon—Dr. William B. Wild, city health commissioner, announced his resignation to accept a position with the Department of Health of Virginia.

Norwalk—Dr. I. M. Hinnant, Cleveland, addressed the Norwalk Kiwanis Club on the subject of the dangers of socialized medicine.

Piqua—Dr. George A. Woodhouse, Pleasant Hill, secretary of the Miami County Medical Society, spoke on the subject of "Government Controlled Medicine," before the local Rotary Club.

Wooster—Dr. Walter B. Lacock, chief of the Cancer Division, Ohio Department of Health, Columbus, addressed the Wayne County Cancer Society.

Xenia—A flagpole near the entrance walk to the home of Foody-Cornwell Post, American Legion, honors the memory of the late Dr. Ben R. McClellan, a past-commander of the post.

Xenia—The memory of two pioneer physicians are being honored by street names in the new hospital site. Martin Avenue was named in memory of Dr. Samuel Martin and Wilson Drive was named in memory of Dr. S. S. Wilson.

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Advisory Committee to Public Health Service Named

A ten-member national advisory committee to the Public Health Service on all phases of industrial hygiene has been appointed, Dr. W. Palmer Dearing, Acting Surgeon General of the Public Health Service, Federal Security Agency, announced.

The committee members, all leaders in various fields of industrial hygiene, will bring together the viewpoints of management, labor, the health professions, and State health and labor departments, Dr. Dearing said.

Members of the committee are: Andrew Fletcher, president of the St. Joseph Lead Company, New York; Vincent P. Ahearn, of the National Sand and Gravel Association, Washington, D. C.; Nelson H. Cruikshank, of the American Federation of Labor, Washington, D. C.; Harry Read, of the Congress of Industrial Organizations, Washington, D. C.; Theodore F. Hatch, research director of the Industrial Hygiene Foundation, Pittsburgh; Dr. R. H. Hutcheson, commissioner of public health for the State of Tennessee; Dr. Harold A. Vonachen, medical director of the Caterpillar Tractor Company, Peoria, Ill.; Dr. Leo Price, director of the Union Health Center of the International Ladies Garment Workers Union, New York; and Mrs. Margaret Lucal, of Willoughby, Ohio, of the American Association of Industrial Nurses. A tenth member, from one of the state labor departments, is yet to be appointed.

Commission To Study Disability Unemployment Insurance

Under the provisions of Amended Senate Bill 134, a nine-member commission has been created "to study temporary disability unemployment insurance fund for the State of Ohio." The commission consists of three members of the State Senate, three members of the State House of Representatives and three named by the Governor.

The members are: Senate—Orval E. Whitacre (D), Minerva; Edward Welsh (D), Dayton, and Tom V. Moorehead (R), Zanesville. House—Ed Witmer (D), Canton; Mark McElroy (D), Cleveland; and Ralph L. Humphrey (R), Ashtabula. Appointees—Dr. Edison L. Bowers, chairman of the Department of Economics, Ohio State University, and a member of the Advisory Council to the Ohio Bureau of Unemployment Compensation; Herbert L. Lannert, director of Industrial Relations of the Crowell-Collier Publishing Co., Springfield, and J. Vincent Aug, president of the Hamilton County Democratic Veterans Club.

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Veterans Administration

A recent study of the Veterans Administration disclosed that the 2,535,385 veterans enrolled in schools and job training establishments under the G-I Bill and Public Law 16 are working toward a wide variety of employment objectives.

In the on-the-job training field, more World War II veterans are learning to be mechanics and repairmen than any other single category of occupations. Of 85,348 veterans in this type of training, 55,766 were learning automobile repairing, 1,644 were studying to be airplane mechanics and 1,135 were being trained on the job to be railroad and car shop mechanics. Another 26,803 were learning other types of mechanics and repair work.

Thirteen per cent of all veterans training in schools and on-the-job, a total of 340,876, were taking institutional on-farm training and other agricultural courses. Twelve per cent, or 322,264, were taking business and financial training. Nearly 100,000 veterans, at the time of V. A.'s survey, were studying advertising, selling and related subjects. Another 100,000 were preparing for teaching careers.

More than 83,000 veterans were studying medicine and related subjects, such as dentistry and pharmacy.

Approximately 64,000 ex-servicemen were pursuing art and related subjects, such as architecture, design and landscaping. More than 46,000 veterans were studying law in colleges and universities throughout the nation. Approximately 15,000 were studying theology. Veterans following other objectives included: music, 23,900; insurance, approximately 8,000; ground phases of aviation, approximately 12,000.

* * *

Beginning July 1, 1950, the Veterans Administration will offer 259 internships to qualified graduates of recognized medical schools. Thirteen V. A. hospitals will participate in this program, which is part of the plan to expand medical teaching facilities in V. A. hospitals.

* * *

Some 1,300 paralyzed veterans have been certified eligible for Federal grants up to $10,000 each to help provide them with homes specially designed and constructed for wheelchair living, Veterans Administration said today.

The grants were authorized in an Act passed by Congress last year, under which V. A. defrays up to 50 per cent of the cost of such homes for eligible veterans with a $10,000 maximum.

Eligible under the law are veterans paralyzed due to service-connected injury or disease of the spinal cord which deprives them of the use of their legs and lower part of the body.

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First Half of 1949 Shows Birth Rates Still Are High

The number of births in the United States for the first half of 1949 was approximately the same as for the corresponding period last year, but somewhat below the record first six months of 1947, the Federal Security administrator announced.

A total of 1,706,000 live births is estimated to have been registered from January through June of this year as against 1,694,000 for the first half of 1948. The only year in which the number of births in the first six months exceeded this year's figure was 1947, when the total for the period was 1,865,881.

The estimated birth rate for January-June, 1949, is 23.1 per 1,000 population excluding the armed forces overseas. Last year the rate for the comparable period was 23.3. The birth rate in the second half of 1948 was appreciably higher and the rate for the entire year was 24.4. In 1948, the number of births for the whole year was 3,559,000, which was only slightly below the all-time high of 3,699,940 recorded for 1947.

The foregoing figures refer only to registered births. When unregistered births are included, the total for January through June, 1949, is estimated at 1,777,000 as compared to 1,768,000 for the same period in 1948.

Heart Research Grants

National Heart Institute grants of more than $1,200,000 to support heart disease research work in medical schools and hospitals in 21 states, the District of Columbia and Canada were announced as approved by the Public Health Service following recommendations by the National Advisory Heart Council.

Additional grants for new heart research and for construction of heart research facilities and laboratories are expected to be announced shortly.

Included in the grants are the following in Ohio:

Cleveland Clinic Foundation, Dr. Irvine H. Page, "Hypertension; Mechanisms; Management;" $18,000;

Western Reserve University, Dr. Claude S. Beck, "Revascularization of Heart," (supplementary grant), $6,000;

Western Reserve University, Dr. Ewald E. Selkurt, "Basic Interrelations of Renal and Cardiovascular Dynamics," $13,554.

With the recent approval of the Board of Thoracic Surgery, there are now 19 examining boards in the specialties which have been approved by the Advisory Board for Medical Specialties and by the Council on Medical Education and Hospitals of the American Medical Association.

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1947 Percentage of Births in Hospitals Makes Record

A greater proportion of births in the United States were delivered in hospitals or institutions in 1947 than in any previous year on record.

The number of registered live births rose to a peak of 3,699,940 in 1947, according to a report of the Public Health Service. At the same time the proportion occurring in hospitals reached a new high of 84.8 per cent.

An additional 10.1 per cent of births in 1947 were attended by physicians outside of hospitals and only about 1 out of 20 births were delivered by a midwife or other non-physician.

According to the report, 92.9 per cent of births in Ohio were in hospitals and attended by physicians. An additional 6.9 per cent were attended by physicians outside of hospitals.

Twenty-one other states had higher percentages of births in hospitals than did Ohio. Oregon and Washington tied for highest percentage with 98.7 per cent each.

1949 Traffic Accidents Running Higher Than Last Year's

At the half-way mark in 1949, traffic deaths on Ohio state highways outside of municipalities totaled 337 as compared to 316 deaths for the same period in 1948, an increase of seven per cent, according to a report of the Division of Traffic and Safety of the Ohio Department of Highways.

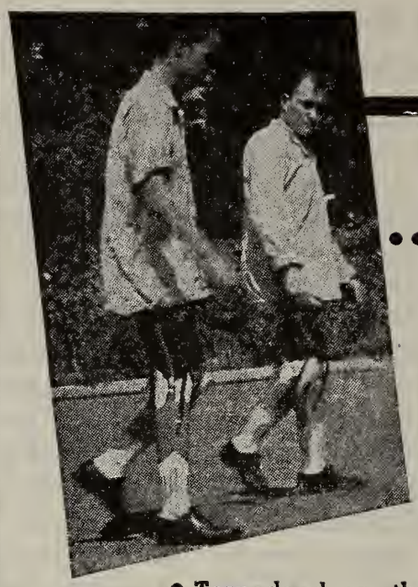
The increase in the death toll was to be expected as motor vehicle travel for the first six months of 1949 was eight per cent over travel during the same period last year. For the first six months of 1949, travel on rural state highways was estimated at 3,735,000,000 miles, a new record high for this period of time.

Persons injured in June accidents this year numbered 1,213 as compared to 1,171 for the same month last year, an increase of four per cent. The injury toll for 1949 now stands at 5,994, an increase of three per cent over the same period in 1948.

The cumulative accident total for 1949 has reached 8,703 as compared to 8,609 for the first six months of 1948.

Rheumatic Fever Library

The Colorado Rheumatic Fever Library has been established at the University of Colorado School of Medicine in response to the need for assembling in one place of all that has been written on the subject of rheumatic fever. It is desired that this library contain reprints or copies of every article that has been written on rheumatic fever.



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GYNECOLOGY—Intensive Course, two weeks, starting Oct. 24. Vaginal Approach to Pelvic Surgery, one week, starting Nov. 7.

OBSTETRICS—Intensive Course, two weeks, starting Nov. 7.

MEDICINE—Intensive General Course, two weeks, starting Oct. 3. Gastroenterology, two weeks, starting Oct. 24. Gastroscopy, two weeks, starting Oct. 24.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 24. Informal Clinical Course every two weeks.

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Research, Training Grants

Grants totaling $489,584 to continue the financing of 35 research projects on mental and nervous disorders and grants totaling $2,554,556, made for training personnel in psychiatry, neurology, clinical psychology, psychiatric nursing and psychiatric social work were announced by the Federal Security administrator. These represent only a portion of the funds which will be allocated for mental health research during the next fiscal year according to the director of the National Institute of Mental Health.

Dr. I. Arthur Mirsky, the May Institute for Medical Research of the Jewish Hospital, Cincinnati, received two research grants—one for $12,420 on the project on measurement of urinary "pepsin" as an index of gastric activity in various emotional states; and $7,128 for the project on the role of psychologic factors in the development of hyperglycemia.

Training grants were made to universities in the state as follows: University of Cincinnati, $65,571; Ohio State University, $14,880, and Western Reserve University, $58,030.

Cortisone Still Available Only For Research Purposes

Because of the wide publicity it has received, there undoubtedly will be considerable interest in the availability of the adrenal cortical steroid, Cortisone, for the treatment of rheumatoid arthritis. An editorial in the August 6 issue of the *Journal of the American Medical Association* makes it clear that the drug will be available on a restricted basis for some time.

"While the value of Cortisone in controlling the symptoms of rheumatoid arthritis is regarded as established," the editorial states, "much remains to be learned concerning its possible untoward effects, its usefulness in other diseases and the mechanism of its action. The small amount which can be made during the last five months of 1949 will be used only for clinical and experimental research and will be made available to those investigators who may best provide the information needed to insure its safe and effective use." Originally obtained from the cortex of the adrenal gland, Cortisone is now being prepared from a bile acid.

The National Academy of Sciences has appointed a Committee on Investigation of Cortisone. Applications for a supply of Cortisone will be considered only from institutions where adequate facilities for investigation and clinical control are available, the editorial states.

"Socialized medicine is the most degrading thing that has ever confronted the medical profession. It means numbers not standards."—*Dr. Leslie Parr, Australian physican.*

Pharmaceutical Association Reaffirms Stand Against Socialized Medicine

The Ohio State Pharmaceutical Association again expressed its opposition to "any form of compulsory health insurance," at its recent 1949 State Convention in Toledo. The organization is one of many groups which, with the medical profession, are forming a solid front against the encroachments of socialized medicine.

Another resolution passed by the pharmacists was one authorizing the placing of exhibits interpreting various phases of professional pharmacy services at the Annual Meeting of the Ohio State Medical Association and at local and county meetings of medical societies.

Other resolutions included the following:

That pharmacy services rendered by hospitals be under the supervision of a registered pharmacist;

That the Association condemn the opening of prescription shops by physicians in clinics;

That the Association support H. R. 4203 (Durham Bill) now before Congress to exempt prescriptions from the Federal Food, Drug and Cosmetic Law; and

That manufacturers of drug products be induced to classify or designate by marking barbiturates, narcotics and dangerous drugs.

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Eighth District To Hold Meet In Cambridge

The Annual Fall Meeting of the Eighth District of the Ohio State Medical Association together with the Eighth District Woman's Auxiliary will be held at the Cambridge State Hospital, Cambridge, on Thursday, October 6.

The program will start at 1:30 p. m. and will include the following speakers and subjects:

"Early Treatment of Mental Disorders," by Dr. Arthur T. Hopwood, superintendent of the Cambridge State Hospital.

"Common Dermatological Problems," by Dr. F. Gordon Lawyer, Cambridge.

"Carcinoma of the Bowel," by Dr. Robert M. Zollinger, Ohio State University College of Medicine.

Luncheon will be served by personnel of the hospital between 12 noon and 1:30 p. m.

Detroit General Practice Lectures

The American Academy of General Practice of Wayne County (Michigan) will hold its third annual post graduate lectures for general practitioners on Wednesday and Thursday, October 26, 27, at the Henry Ford Hospital Auditorium, Detroit, Mich. Detailed information may be obtained from Dr. Karl L. Swift, 869 Fisher Bldg., Detroit 2, Mich.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18, 1950, Cleveland.

American Medical Association, Annual Session, San Francisco, Calif., June 26-30, 1950.

American Medical Association Interim Session, December 6-9, Washington, D. C.

A. M. A. School Health Conference, October 13-19, Hotel Moraine, Highland Park, Ill.

Eighth District Meeting, Cambridge State Hospital, Cambridge, October 6.

International Congress of Surgeons, U. S. Chapter, 14th Annual Assembly and Convocation, Atlantic City, N. J., Nov. 7-12.

National Society for Crippled Children and Adults, Annual Convention, New York, November 7-9.

Northwestern Ohio Medical Association (Third and Fourth Districts), Commodore Perry Hotel, Toledo, October 4.

Sixth Councilor District of Ohio State Medical Association, Annual Postgraduate Day, Youngstown, November 30.

Trumbull County Medical Society Post Graduate Day, Warren, November 16.

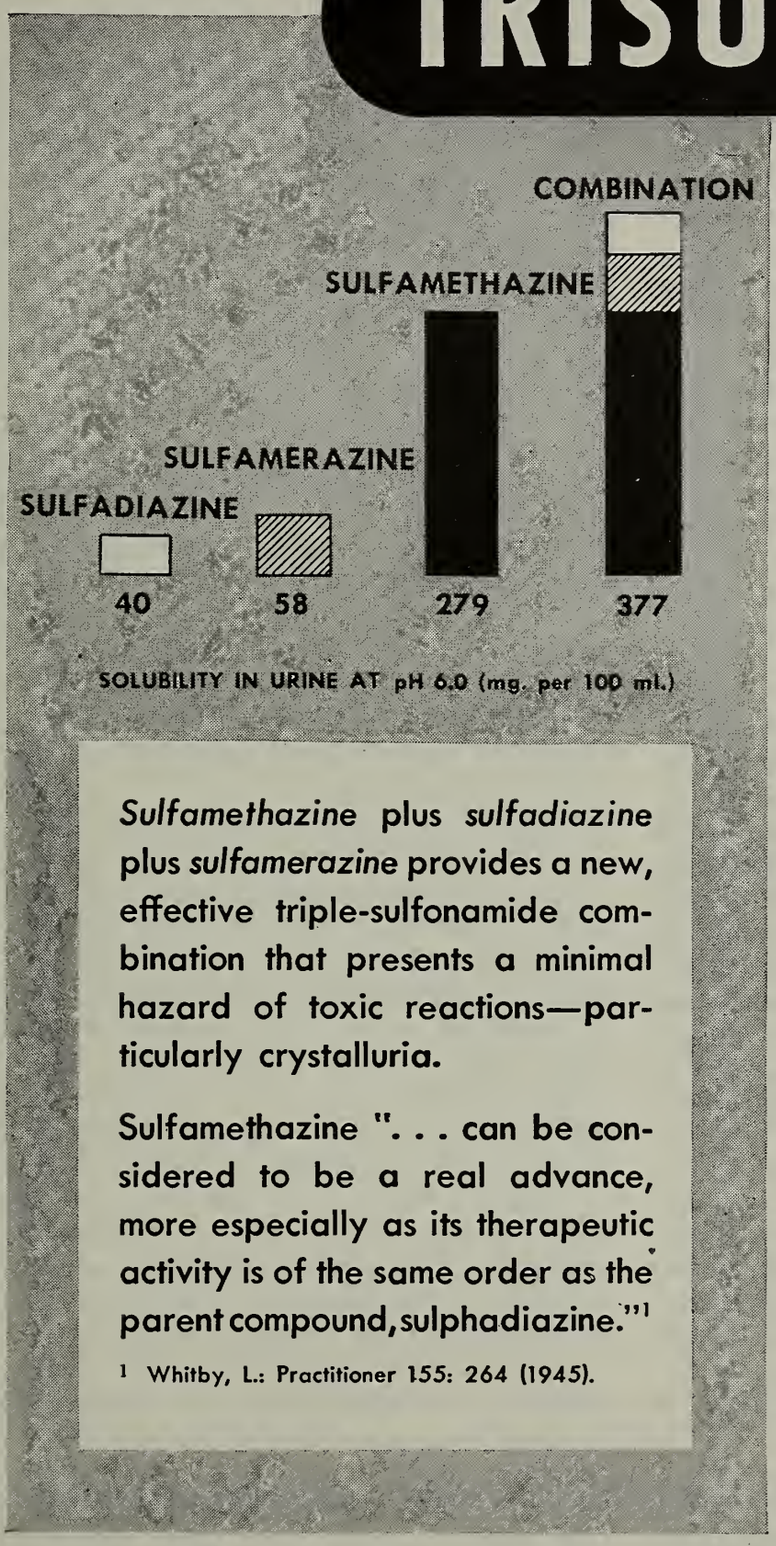
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[1] Whitby, L.: Practitioner 155: 264 (1945).

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Your Child and Mine

IN a symposium on the modern city a couple of years ago, I wrote that most of the education of our children today is *mis*-education. Our children no longer get the real concept of life from their parents or their teachers but from the hucksters who sell them on white flour and its enrichment, pasteries, sweeten carbonated beverages (often containing raw phosphuric acid) to ruin their health. These same advertising copy writers teach our youth that it is smart to drink alcoholic beverages and smoke cigarettes. My quarrel with our educational system is that our teachers are no longer professional people, they have been regimented into servants of the school administration.

(Cities Are Abnormal—A Symposium, edited by Elmer Peterson, $3.00, *The University of Oklahoma Press, Norman, Oklahoma.)*

Our modern city with its noise, its cramped quarters, its late hours, and its tense, irritable, malnourished inhabitants, makes a poor place to raise a child or to keep a pup. Parenthood is the most thrilling job you ever tackled but it is also the most demanding. On the other hand, the aseptic routine of the hospital may give the mother the idea that it will be almost impossible to do without it when she gets home and has suggested to someone the popular song *"I Can't Give You Anything But Love, Baby."* With all of our science we must not forget that Mother is an infant's most important *right.* Regular readers of the *New York Times* on Sundays know what an excellent page in the magazine section Catherine Mackenzie has produced for many years. William Sloane has gathered the best of these into a book of 330 pages. **(Parent and Child,** $2.95, *William Sloane Associates, New York City.)* No better summary of what is known for certain about the care and emotional development of children is available.

The "forgotten years of childhood" are the school years between the nursery and adolescence. For this reason, Clara Lambert has written an excellent pamphlet about them. **(Understand Your Child, Ages 6-12, Public Affairs Pamphlet No. 144,** 20 cents, *22 East 38 Street, New York City.)* Again we come back to the big defects of our times. Parents have no time to share with their children; no time to talk things over. Children often have no responsibility, no chores to do. Gifts and professional care too often take the place of love. There can be no substitute for the feeling of security that comes from knowing that your parents wanted you, that you did not just happen along as an additional burden to urban living. To know down deep in your heart that your parents actually love you makes for a mental hygiene that nothing can upset. Nowhere is this more needed than in the case of the allergic child.

Lambert's advice is worth repeating: "By knowing what to expect but not expecting more than the possible you can help your child develop. You cannot give him more intelligence than he was born with, more talents than he has, nor more beauty than he inherited. No pressure, nagging, force or punishment can change him into your dream child. He can be helped to grow, not painlessly, for growth brings pain with it. Accepting him for what he is and loving him, too, creates an atmosphere in which to weather the storms of growing up."

In these days when everyone is trying to probe into the other fellow's mind, it is but natural that there should be inquiries into the emotional needs of the child. So, a group of pediatricians and psychiatrists were assembled for such a discussion. **(Pediatrics and the Emotional Needs of the Child,** $1.50, *Commonwealth Fund, New York City).* Most of what was said was plain common sense in a re-examination of the parent-child and physician-child relationship. The important facts are well set forth in plain English in the above-mentioned book, but here we get it in the jargon of the specialist. It may all be summed up in saying that every physician must understand the mind of his patients—be they big or little.

Social workers and psychiatrists insist that guidance of children and their mothers during the first five years of life will do much to prevent the development of unhealthy attitudes towards self and society, the crippling personality pattern found in adults who suffer breakdowns or serious damage to personal efficiency which are generally believed to be traceable to causative factors operating during childhood. Working at the most effective age—the preschool years —the Mothers' Advisory Service at Johns Hopkins has investigated its results. They conclude that their guidance was of value and rightly

show that their four distinct failures were due to extremely neglectful or neurotic mothers. (**Evaluation of the Mothers' Advisory Services,** by Marcia Mann Cooper, Monograph on Research in Child Development, Volume XII, Serial No. 44, No. 1, *National Research Council, Washington 25, D. C.)*

ADOLESCENCE

There has been great need to bring together in a readily accessible form the relevent findings from long-term studies of human development, from anthropological records of differing social patterns, and from observation of the therapeutic effects and group membership in schools, in the armed forces, and industry—all that could help us to understand the nature and needs of adolescents. Upon a fuller appreciation of what is really known and what is superstition depends upon how wisely we handle their youths. Upon their wise handling depends the issues of ultimate harmony or conflicts in the home, in the workshop or factory, and among nations. C. M. Fleming has assembled these data for us. (**Adolescences,** Its Social Pathology: With an Introduction to Recent Findings from the Fields of Anthropology, Physiology, Medicine, Psychometrics and Sociometry, $4.50, *International Universities Press, New York City).*

A full appreciation of the material in this book would lead to rather remarkable modification of current procedures in industry, international relationship, in schools and home. In short, one of our outstanding problems is how to get matured minds and personalities in our citizens of the coming generation.

Adolescence is a period of transition, when youth begins to think of the future. With these thoughts come many problems—emotional problems, adjustments in family life, in school and social life including sex problems and moral and religious orientation. W. S. Sadler, the well-known psychiatrist, has brought out a companion volume to his **Doctor Talks to Teen-Agers,** for physicians, parents, and teachers (**Adolescence Problems,** $4.75, *C. V. Mosby Company, St. Louis, Missouri),* which gives us the advice and experience of forty years' of counselling. The author points out a warning to us parents that many of the problems brought to him through the years turned out to be problem teachers or problem parents.

In an international tribute to August Aichhorn, **Searchlights on Delinquency,** edited by Paul Federn, M. D., $10.00, *International Universities Press, Inc., New York City,* presents the psychoanalytic approach to the same problems of delinquency. In its broader concept as the genetic psychology and pathopsychology of the conscious and the unconscious mind, it has contributions of considerable merit to make to this pressing problem of modern society.

There are two ways to approach the health problems of the children of the United States. First, the positive approach by which health officers would use public funds efficiently to prevent the spread of communicable diseases and the school teacher would motivate our children to make every effort to keep their health. This would result in a sound diet for everyone with sufficient exercise to insure the muscular tone necessary for good digestion. This would not call for additional personnel. It merely asked that those who prevent the spread of communicable disease do their job and those who are trained to teach, do teach our children how to live within the biological "norm."

The second approach is the negative one: How to take care of disease without ever asking its real cause. This reminds us so much of the work of our Army Engineer Corps who have spent billions of the taxpayers' money building levies and dams for flood control but who have not asked themselves what causes floods. So, all this money and effort will be wasted unless soil conservation is practiced upstream and the rain put into the ground when it falls.

The American Academy of Pediatrics has made a careful study of the available health services and pediatric education but with the narrow grandeur concept which every specialist has of his own importance and that of his special field of technical knowledge. That we need better teaching in our medical schools—not more hours—there can be no doubt; the refresher courses are helpful. Child-specialists are needed for consultation and management of the infrequent but baffling cases. But that there should be a pediatrician for every child in the United States is absurd. What the rank and file of youngsters and oldsters, too, need is not pediatricians and geriatrists, but good well-rounded, human, family physicians who know and love people and are willing to admit when they do not know what some pediatrician *might know.*

Cardiac Catheterization in Congential Heart Disease, by Andre Cournand, Janet S. Baldwin and Aaron Himmelstein, ($4.00. *The Commonwealth Fund, New York City)* presents the brilliant work of this great team in terms of the details of 17 cases.

Public Health in the World Today, edited by James Stevens Simmons, ($5.00. *Harvard University Press, Cambridge, Mass.)* gives the 23 lectures presented last year at the Public Health Forum at the Harvard School of Public Health. Everyone of us should study this book to get a perspective.

* * *

The correct price of **Recent Progress in Hormone Research,** Proceedings of the Laurentian Hormone Conference, *(Academic Press, Inc., New York)* is $7.80.

The common occurrence of mixed infections in burns and chronic wounds suggests the use of an antibacterial agent with a wide antibacterial spectrum. Furacin, effective against the majority of wound bacteria in vivo, is receiving favorable and steadily increasing mention in the literature for such conditions.* Furacin® brand of nitrofurazone, is available as Furacin Soluble Dressing (N.N.R.) and as Furacin Solution (N.N.R.) containing 0.2 per cent Furacin. These preparations are indicated for topical application *in the prophylaxis or treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.*

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*Bigler, J.: Chicago M. Soc. Bull. 50:269, 1947 • Coakley, W. A. et al.: Plast. & Reconstruct. Surg. 3:667 (Nov.) 1948 • Curtis, L.: Surg. Clin. N. A. 1466 (Dec.) 1947 • Downing, J. et al.: J. A. M. A. 133:299, 1947 • Johnson, H.: Arch. Dermat. & Syph. 57:348, 1948 • Mays, J.: J. M. A. Georgia 36:263, 1947 • McCollough, N.: Indust. Med. 16:128, 1947 • Mills, J. et al.: Plast. & Reconstruct. Surg. 3:245, 1948 • Ryan, T.: U. S. Nav. M. Bull. 47:991, 1947 • Shipley, E. et al.: Surg., Gynec. & Obst. 84:366, 1947 • Snyder, M. et al.: Mil. Surgeon 97:380, 1945.

For mixed infections



The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit corporation, with a definite membership, for scientific and educational purposes.

Vol. 45 November, 1949 No. 11

JONATHAN FORMAN, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Thromballosis*

WILLIAM W. WEIS, M. D.

MORBIDITY and fatality following surgical interventions from venous thrombosis and pulmonary embolism have been progressively on the increase in recent years. For the past five years enthusiastic interest has been shown, not only by the surgeon, but by the obstetrician and internist as well. The literature on the subject of thrombophlebitis, phlebothrombosis, and pulmonary embolism has become voluminous.

Many factors seem to contribute to the incidence of intravenous occlusion. The character and magnitude of the operative procedure seems to be the greatest single factor. The number of operative interventions as well as the extent of the same with their associated shock, has undoubtedly increased this complication. Age limits are now greatly extended and Allen, et al., have shown that 81 per cent of their cases were in patients over forty years of age.

The site of the operative field also increases this incidence of thrombosis and the Mayo Clinic in a group of 1,665 consecutive cases has had a three per cent occurrence in pelvic operations on the female, while the per cent was only two in laparotomies and slightly under one per cent for all operations. Barker and Priestley have also shown that patients with carcinoma, peripheral vein disease, cardiac disease, serious infections, and blood dyscrasias were more prone to have these complications.

Besides the trauma incident with surgery other factors are contributory: Circulatory retardation produced by posture, such as the Fowler position after abdominal surgery with the thighs practically flexed on the abdomen and the legs on the thighs, causing a pooling of blood in the popliteal veins, greatly increasing venous stasis.

Immobility of the diaphragm caused by tight abdominal strapping postoperatively producing an increased abdominal tension especially in the presence of gas is another factor.

There are familial and constitutional tendencies with an increased occurrence in the asthenic, adipose type of person who is hypothyroid, overweight or weak-muscled.

Climate and weather have their predisposition. Faure demonstrated a greater incidence in the winter months especially when upper respiratory and la grippe infections are prevalent. More cases are reported in northern states than in the south.

Ochsner and DeBakey have shown that tobacco and its associated vasospasm retarding the flow of blood in the lower extremities is contributing.

THEORIES AS TO CAUSE

Many theories as to the development of venous thrombosis have been postulated. Frykholm's theory seems the most plausible. Because of in-

The Author

Dr. Weis, Piqua, Ohio, is a graduate of Ohio State University College of Medicine, 1923; member, International College of Surgeons, American Assn. of Industrial Physicians and Surgeons, American Assn. of Railway Surgeons; on senior surgical staff, Ball Memorial Hospital, Piqua, and Wilson Memorial Hospital, Sidney, Ohio.

* The condition of the venous blood produced by coagulation. W. A. Newman Dorland, M. D.

Submitted January 24, 1949.

activity, trauma, and posture with lowered venous pressure, there is a relative collapse of the veins in the lower extremities, with the result that the endothelial cells lining the venous walls may adhere together. The injured cells become defective, roughened or torn loose, or thrombocytes and leukocytes may adhere to them; in either case these cells act as a nidus for a thrombus. The leukocytes follow along the wall of the vessel while the erythrocytes are usually formed in the center.

There is a change in the constitution of the blood itself. The plasma changes are an increase of the viscosity with an increase in fibrogen and calcium content as well as by hyperglobulinemia and hypoproteinemia. There is also an increase in the cells of the blood manifest by more thrombocytes and leukocytes as well as a tendency to their agglutination. This so happening small vessels may be easily occluded.

James F. O'Neill's recent studies of the effects on venous endothelium of alterations in the blood flow through the vessels in vein walls, and the possible relation to thrombosis have been most illuminating. He has demonstrated that obstruction of the vein with or without isolation or severing the vasa venarum, there is an endothelial damage and concomitant intravenous clotting. He proposes, in given low oxygen values as the hypoxia from deep or prolonged anesthesia or narcosis; any interference with pulmonary ventilation; poor oxygen transportation as in some cardiovascular diseases; occlusive arterial diseases of the extremities; or diminished blood flow to a resting or immobilized limb the arterial blood entering an extremity, both the blood nourishing the wall of the vein as well as the blood returning in the vein lumina may have proportionate decreases in their respective oxygen levels. It is conceivable that under such conditions, venous endothelium is caught in the middle, between two poor oxygen sources whose total supplies are scarcely adequate to keep it intact. Add then stasis and time, and a clot may promptly form.

METHOD OF PREVENTION

Prophylaxis is a great bulwark in the prevention of venous thrombosis and if rigorously adhered to, the incidence can be greatly reduced.

The patient contemplating surgery who has malignancy, peripheral vein disease, cardiac disease, serious infections including tuberculosis and hematic diseases, has to be carefully guarded and protected from this complication.

Overweight patients as well as the anemic and asthenic patients having an elective procedure should have proper constitutional therapy before surgical intervention.

Donaldson reports from Massachusetts General Hospital in 1925 that there were three fatal pulmonary emboli in every one thousand operations. Ten years ago, with the introduction of more careful attention to the position of the patient on the operating table, active and passive leg exercises postoperatively, encouraged deep breathing, routine elevations of the foot of the bed to speed venous return, and finally earlier ambulation, the incidence of fatal embolism has dropped to one death in eight hundred operations.

The immediate preoperative care should give adequate attention to the acid-base balance, mineralization and hydration. Smoking before and after operation should be avoided because of its nicotine vasoconstrictor effect. Bed rest should be minimal to minimize the calf vein stasis and pressure accompanying it; especially so in the previously active individual. Chilling before, after and during the operation should be avoided.

Check of the prothrombin time will give a clue as to the necessity of pre- as well as postoperative anticoagulant therapy and will eliminate some patients who have a persistent disposition to clotting.

The operation should be an atraumatic procedure with accurate hemostasis, the elimination of large ligatures and mass ties. Normal arterial pressure should be maintained during the operation.

Posture is important; legs should not be allowed to hang down. Postoperative Fowler position should be avoided and preferably the foot of the bed should be elevated eight to twelve inches. Compression bandages should be applied in the case of varicose veins. In abdominal distension tight abdominal binders should be eliminated. Hyponea should be overcome by deep inspiration exercises every hour. Early exercise of the lower limbs is of inestimable value. Early ambulation with patients out of bed soon following surgery has proven to be the greatest single factor preventing postoperative thrombosis.

The Lahey Clinic has a dictum—wiggle your toes and feet one thousand times a day. In the past five years since its introduction as part of the routine care of surgical patients there have been only 238 cases of marked venous clotting in some 56,000 major surgical operations.

The anticoagulants in selected cases where thrombosis may be anticipated are useful. Dicumarol and heparin have been the most widely used.

TYPES OF THROMBOSES

Thrombosis is primarily confined to the lower extremities. This intravenous clotting may be divided into two major types each in itself bridging into the other's domain, extent and type. They are classified into those of thrombophlebitis and phlebothrombosis. Doctors Ochsner and DeBakey have defined thrombophlebitis

as a partial or complete venous occlusion by an intravascular clot which is associated with and dependent upon inflammation of the vein walls; and phlebothrombosis as a partial or complete venous occlusion by an intravascular clot which is unassociated with inflammation, the clot remaining loosely attached to the vein walls. That clotting in thrombophlebitis is the result of injury to the vascular endothelium from mechanical trauma, bacterial invasion, or chemical injury; whereas, in phlebothrombosis the intravascular thrombus formation is due to venous stasis and to alterations in the cellular and fluid constituents of the blood which increase the clotting tendency. The prognostic significance of this differentiation lies in the fact that in thrombophlebitis, unless there is suppuration, which is rare, the clot is firmly adhered to the vein wall and therefore is less likely to become detached and result in an embolism. Because of the associated inflammatory process, there is more likely to be an accompanied arteriolar spasm resulting in edema. In phlebothrombosis the coagulum is loosely attached in the vessel wall, can be detached easily, and therefore is likely to cause embolism. It is less frequently associated with vasospastic influences and for this reason is commonly overlooked until the thrombus becomes detached, producing embolism.

Each has its most selective site. Thrombophlebitis with its maximum changes in the vessel walls and paravenous lymphangitis is usually found in the deep portion of the femoral iliac system. The more usual sites of the thrombus in phlebothrombosis are the tibial, their tributaries, and plantar veins. Pathologists have shown in patients of enforced bed rest that where post mortem examinations of the legs are made, ante mortem thromboses are found in the deep veins of the calf in fifty to ninety per cent of cases depending on age.

Donaldson expresses the opinion that the extremes of acute thrombophlebitis on the one hand and phlebothrombosis on the other are expressions of an identical process. Between them are all gradations, the picture depending on the extent of involvement of the vein intima and the inflammatory process. There is much discussion whether the thromboses begin in the femoral iliac system and extend to involve the deep venous system or whether it begins in the plantar and calf muscle veins and extends to involve the femoral iliac system. Most often the inflammatory reaction is an aseptic one, and the extent of the endothelial damage is dependent on such factors as the degree of local anoxia and general alterations in the cellular and fluid contents of the blood which tend to increase clotting proficiency. At the greatest extreme, the so-called thrombophlebitis, there is found diffuse swelling, tenderness, warmth, and pain in the calf on dorsiflexion of the foot. The superficial veins over the ankle and forefoot are distended, and there is a leucocytosis, elevated sedimentation. When the thigh is noticeably swollen and the superficial veins dilated, the iliac vein is also involved. Chills and picketfence type temperature curve indicate that suppuration is present. Here the clot is firmly adherent to the vein wall over some distance and the likelihood of a large, death-producing embolus is slight. When they do occur they are usually of the septic type mentioned. This type if it does not kill by several repeated smaller emboli, enforces a prolonged hospital stay and results in a permanently impaired leg due to valvular destruction.

The gradation of the bland type, the so-called phlebothrombosis, are many. Minimal swelling of the ankle, however, edema of the foot and leg, is seen in about sixty per cent of cases; local areas of fullness of the long saphenous vein at the ankle, associated with mild systemic reaction indicate that the clot coagulum is adherent to only a small area of vessel intima. The patient is often very nervous, and has an anxious look of impending danger. Propagation is chiefly cephalward, and should the thrombus free itself, a long column of clot is liberated to the right heart and pulmonary arteries.

It, therefore, appears evident that the picture of deep leg vein thrombosis is not constant. Any gradation of inflammatory reaction may occur, from the point of no evident inflammatory reaction at all to one of suppurative thrombosis and infected emboli. The sight of election may be any place in the lower venous system with a greater selectivity for thrombosis per se in the lower leg or foot and phlebitis to the upper leg.

Clinically, pulmonary emboli arising from the leg veins as a source, are becoming recognized by symptoms and signs often regarded in the past as indicative of primary disease of the heart or lungs or as an inconsequential digestive disturbance. A single symptom in itself is not sufficient to make the diagnosis, but, often enough, calls attention to the presence of other obscure signs which give added evidence of the presence of vascular pathology. At the Massachusetts General Hospital 59 per cent of patients presented leg signs as the first indication of thromboembolic disease; and of these, 67 per cent showed leg swelling; 61 per cent, tenderness over the tibial vessels, and 42 per cent a positive Homans' sign. The remainder 41 per cent presented chest symptoms as the first indication of disease. Great reliance is placed on the appearance of the clinical chart. Any patient who, otherwise convalescing smoothly, suddenly develops a simultaneous rise in temperature, pulse and respiration is suspected of harboring phlebitis or having a

subclinical pulmonary embolus until proven otherwise.

Sharp sudden pain in the chest as a result of pulmonary embolus was the first indication of the disease in a series of studies by Allen. If the emboli are small, they may produce only pleuritis or substernal pain, faintness, coughing or bloody sputum; if they are massive they may result in sudden death. The lower lobes of the lungs are involved 96 per cent of the time, the fact of which assists in making a differential diagnosis.

TREATMENT

Active treatment of thromballosis has established itself into three forms varying itself with the type of thrombosis predominant. These are lumbar sympathetic block, anticoagulants and deep vein interruption. Obviously in some cases all three measures can be used to advantage. In the thrombophlebitic type where primarily there is no danger of embolism, lumbar sympathetic block with its resulting vasodilatation produces an immediate improvement of the patient's condition. The pain almost disappears immediately; the temperature rapidly returns to normal; pulsations reappear in the dorsalis pedis and the posterior tibial artery. The skin becomes soft and edema gradually disappear in three to ten days.

Ochsner employs the four-needle technique in doing his lumbar sympathetic block. The first, second, third and fourth lumbar sympathetic ganglion are blocked with ten cc. of one per cent procaine hydrochloride solution at each portal.

Dr. John Homans prefers to use a one-needle technique in the first interspace with ten to twenty cc. of one per cent novacaine solution. He inserts the needle from a more lateral position than the technique described by Ochsner. His only objection to the more lateral direction is that on the left side, upon passing the vertebra, one may enter the aorta. In his experience the few times that this has occurred there have been no bad effects.

Both Ochsner and Homans agree that a single needle should be sufficient, but the four-needle technique constitutes an effort to increase the chance of success with one of them.

In occasional cases it may be required to repeat the block daily for two to four days.

This disrupts a harmful reflex arc and produces a normal arteriocapillary circulation. In addition to the block the leg is elevated until the edema disappears, which is almost always the case when treatment is instituted early as the condition develops. With the edema diminishing active exercise is advised. When there is persistence of the edema after the patient is allowed up, an elastic stocking or bandage may be worn from two to six weeks to include the foot and leg extending above the knee. The Unna paste boot is most efficacious at this time.

Anticoagulants should be given. The preference as to heparin or dicumarol depends upon the speed of action desired, the condition of the patient and appropriate laboratory facilities. The anticoagulants will avoid progression and extension of the thrombosis as well as act prophylactically with the respect to the opposite side. Actually emboli frequently are attributed to a silent deep thrombosis of the contralateral side.

Surgical treatment if indicated and it is rarely so, may be necessary in those cases of suppuration at the site of the thrombophlebitic process, with resultant liquefaction of the clot and the production of infected emboli. Ligation of the diseased process proximal to the lesion is imperative to prevent extension sepsis and fatal embolism.

For patients who have repeated pulmonary emboli, interruption of the venous return may be desirable. William J. Hintan expresses the difficulty in determining for surgical treatment the exact site of the thrombosis. His experience with the patients who really need vein ligation is that ligation of the vena cava is preferable to other procedures and is the only sure means of entering well above the thrombus.

Homans, Allen, Lintan and Donaldson have demonstrated the value of ligation and prefer it as the treatment of choice.

The superficial femoral as well as the deep femoral are the preferred sites of election. Donaldson reports 554 prophylactic femoral vein interruptions with fifteen cases of clinical phlebitis developing and one fatal pulmonary embolus. This is compared with a similar series developing a phlebitis in sixty-three cases and thirty fatal emboli without a ligation.

Geza DeTakats for many years has ligated the superficial femoral vein prior to leg amputations and has shown conclusive evidence that such a procedure cuts down both morbidity and mortality. He, however, considers the administration of the anticoagulants preferable in those groups usually requiring protective therapy such as the immobilized older individual and those of the high incidence of thrombo-embolism such as hip fractures.

Vein ligation cannot be classified as an innocuous procedure and any other site higher than the superficial femoral will have a morbidity in over forty per cent of cases of inadequate venous drainage of the limb. Ligation higher than this point such as the common iliac or vena cava, is progressively being reserved for those cases of septic pulmonary embolism from the pelvis or lower limb and those cases of pulmonary embolism occurring a week or more after previous femoral ligature. Intermediary attitudes as to the choice of vein ligation or the

employment of anticoagulants are held by many. The opposite school of thought pronounces the theory that intravascular clotting should be controlled by limiting the coagulability of the blood itself. The Mayo Clinic condemns surgical treatment and considers antocoagulant treatment superior.

In its report of 273 cases of thrombophlebitis without ligation or anticoagulant therapy there were eighteen deaths from pulmonary embolism. Autopsy revealed that four of these occurred eleven to thirty-two days after the onset of the disease and that the embolism came from a fresh thrombus in the opposite ilio-femoral vein. Also in a series of 1,180 patients operated upon —one-half given dicumarol—autopsy revealed that in the dicumarol group there was seventy-five per cent fewer cases of thromboembolic disease and one death only from pulmonary embolism.

Loewe and Hirsch have demonstrated that the prevention and termination of the progressive thrombotic process can be produced by the properties of heparin. The accepted knowledge concerning the mechanism of action of this agent are as follows: (1) It prevents, with the aid of a plasma cofactor the conversion of prothrombin to thrombin; (2) it forms a strong antithrombin in conjunction with serum albumin, and (3) it prevents the formation of thromboplastin from platelets. These properties predicate the fact that a clot regardless of what state it is cannot propagate in the presence of heparin. They have also demonstrated in the laboratory that red cell clots containing minute amounts of fibrin disappear completely under heparin therapy. Heparin therapy maintains patent adjacent collaterals; these tributaries often become as large as the originally occluded vessel and which ordinarily would have been involved in the thromballosis. The disadvantage of the administration and cost of heparin seems now to be practically overcome by its subcutaneous injection every few days incorporated into Pitkins menstruum (William R. Warner Co.).

The ingredients of the Pitkin menstruum are gelatin, eighteen per cent; dextrose, eight per cent; glacial acetic acid, five-tenths per cent and water sufficient to make one hundred per cent. Ampuls containing 200 or 300 mg. with or without a vasoconstrictor of epinephrine and ephedrine are now available. In general the body weight and individual reactivity dictate the amount of heparin Pitkin menstruum to be used.

It is advisable to inject the heparin into the thigh which is normal. Avoid using the affected thigh for deposition of heparin until the swelling has partially receded.

For uncomplicated thrombophlebitis and/or phlebothrombosis, inject subcutaneously an initial dose of 400 mg. of heparin sodium salt (1 ampul, 2 cc., 220 mg. of heparin sodium salt, with vasoconstrictor drugs, plus 1 ampul, 2 cc., 200 mg. of heparin sodium salt, without vasoconstrictor drugs) in the Pitkin menstruum, thus forming a deep subcutaneous deposit. Repeat this dose or a smaller dose (if the response permits) of 300 mg. of heparin sodium salt (1 ampul, 3 cc.) with vasoconstrictor drugs, every other day for seven to fourteen days. Pulmonary embolization demands an additional week or more of heparinization until the patient becomes fully ambulatory. In continuation of the treatment over a period of time, a dose of 400 to 600 mg. of heparin sodium salt (2 ampuls, 200 or 300 mg. each) is required for hypo-reactors, 300 mg. (1 ampul) for hyper-reactors.

Where the use of heparin sodium salt with vasoconstrictors is indicated and two ampuls must be combined to provide the necessary dose for an individual subcutaneous injection, only one ampul of the combination should contain vasoconstrictor drugs in addition to heparin sodium salt. The other ampul(s) should contain heparin sodium salt only. The amount of vasoconstrictor drugs in the one ampul will suffice for the entire dose of heparin sodium salt afforded by the combined ampuls.

As a general rule for effective heparinization, the blood coagulation time need not be more than two or three times the control coagulation time, i. e., thirty to forty-five minutes as contrasted with a control time of nine to fifteen minutes.

There should be little, if any, local pain, swelling and tenderness following the subcutaneous injection. If any of these symptoms develop in any degree, adequate sedation should be prescribed.

Following the administration of a dose of 200 mg. or 300 mg. of heparin sodium salt combined with vasoconstrictor drugs, the patient will occasionally complain of palpitation and nervousness. These reactions require no treatment and disappear within a short time.

Digitalis inhibits the anticoagulant action of heparin. If possible avoid the use of this drug during periods of heparinization.

In hypertensive patients or those with myocardial disease, it is best to use heparin without vasoconstrictor drugs in order to avoid the transitory vasoconstrictor effect. The use of heparin sodium salt without vasoconstrictor drugs is also recommended in cases of thromboembolic arterial disease to avoid the possible complication of arterial spasm.

The use of dicumarol is more selective and should be used cautiously in cases of vitamin K deficiency, inanition, hepatic or renal injury. Its action is markedly augmented during increased body temperatures.

Dicumarol's cost of administration is nominal and in those cases requiring quick action may

supplement severals days of heparin therapy. Its effect is somewhat prolonged and requires in its early use daily prothrombin blood level determinations. This is a laboratory procedure and requires adequate laboratory facilities to carry it out. The occasional case of greatly lowered coagulation time can be overcome by the intervenous injection of 30 to 60 mg. of vitamin K or whole blood transfusions. A satisfactory procedure is to administer 300 mg. of dicumarol the first day having made predicumarol prothrombin blood level determinations. The second day administer 200 mg. of the drug and then each succeeding day the proper amount determined by the prothrombin level determination to keep the coagulation time within a range of 50 to 30 per cent of normal. When coagulation time is above fifty per cent of normal it usually will require a one hundred mg. dose. If the level is between 50 and 30 per cent of normal, 50 mg. will usually suffice. When the level is 30 per cent or less, no dicumarol is given. After a week of such determination the administration is somewhat standardized for the individual case, and prothrombin level determination may be done less often.

The span of anticoagulant treatment should not be discontinued too early and in the uncomplicated thrombostasis administration should continue for two or three weeks. In those cases of pulmonary embolization an additional week or two is required. In all events the full effect should be present when the patient is first allowed out of bed.

The results of anticoagulant therapy have been markedly satisfactory as judged by the effective control of pulmonary embolization, the prompt elimination of pain and discomfort, the rapid recession of edema, the reduction in morbidity, the acceleration of convalescence and the virtual absence of residual edema.

SUMMARY

1. Intravenous thrombosis is augmented by trauma, venous stagnation and time.
2. Thrombophlebitis and phlebothrombosis per se are extremes of the thrombotic spectrum—the condition depending on the amount of associated inflammation or no inflammation at all.
3. Prophylactic venous ligation and postoperative venous ligation have their limited usefulness.
4. Anticoagulant therapy is efficacious and both heparin and dicumarol give good results.

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Anesthetics for the Asthmatic

It seems well established that people suffering from allergies, and especially asthma, are more susceptible to anesthetics than other persons. The success of anesthesia in the allergic patient depends upon proper planning or proper selection of the drugs to be used. The critical time usually comes after the operation is over. Strict care must be given at this time.

Very few cases of allergy to the commonly used inhalation anesthetics have ever been reported. But with the newer drugs and the injectable anesthetics, the story is different. With these, much depends upon the skill of the anesthetist. He should always be given a chance to study the patient before the operation so that he can study the proper drugs intelligently. Not infrequently, it may be necessary to select a second choice of anesthetic agent or procedure, rather than the first (original) choice, because of this complication in the situation.—Richard E. Brennan, M. D., Reading, Pennsylvania; Annals of Allergy, July-August, 1949.

Streptomycin in the Removal of the Tuberculous Lung

MAURICE G. BUCKLES, M.D., and WILFORD B. NEPTUNE, M.D.

THERE is little doubt that resection of tuberculous disease within a lung is of definite clinical value, and is growing rapidly in its understanding. It is the purpose of the authors to review their recent experiences in pulmonary resections, including lobectomies, pneumonectomies and segmental resections, pointing out the actual happenings in fifty-eight cases. They also wish to evaluate as nearly as possible the use of streptomycin in these cases, pointing out the fact that pulmonary resections, plus the use of streptomycin, gives a new hope to a certain group of unfavorable cases which formerly fit into no known therapeutic category.

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HISTORICAL

The first pulmonary resection for tuberculosis was attempted in 1881, by Block,[1] and ended in death during the operation. The first reported successful resection was by Tuffier[2] in 1891. While the idea of resection was appealing, it appeared unwise due to the almost prohibitive mortality and morbidity rate. In 1942, Thornton and Adams[3] reviewed the literature and found twenty-nine reported pneumonectomies for tuberculosis, with a mortality rate of forty-six per cent, and fifty-one lobectomies with a mortality rate of twenty-five per cent. A review of the literature by Moore, Murphy and Elrod[4] in May, 1948, revealed: 587 reported resections with an over-all mortality rate of twenty-six per cent; empyema, twenty per cent; fistula, eleven per cent; spread, twenty-six per cent; and only fifty per cent of the patients having a negative sputum.

The high mortality and morbidity rate discouraged too widespread an application of this surgical approach; however, the ever presence of patients with lesions destined to failure with thoracoplasty (such as tuberculous bronchiectasis, residual cavities, and bronchostenosis), kept the procedure alive. The discovery of streptomycin by Waksman[5] and others in 1943, and the subsequent demonstration of its bacteriostatic effect on the tubercle bacillus,[6] made it apparent that pulmonary resection would become a more frequent procedure in the treatment of tuberculosis.

USE OF STREPTOMYCIN

In contrast to the previous results, Moore, Murphy, and Elrod[4] reviewed the literature for pulmonary resections under the protection of streptomycin, and found: 475 cases with an over-all mortality ranging from 0 to 21 per cent with an average of 9 per cent; and 86 per cent of surviving patients with a negative sputum. Considering that the type of patient undergoing resection was usually one on whom previous procedures had failed, these results seem truly remarkable.

At Franklin County Tuberculosis Hospital, Columbus, Ohio, there have been fifty-eight pulmonary resections for tuberculosis performed by the senior author (M.G.B.), using streptomycin as a protective agent.

INDICATIONS

In this group of patients, the indications used for pulmonary resections were as follows: 1. Failure of pneumothorax or pneumoperitoneum with phrenic crush, 72 per cent. 2. Bronchiectasis, 6 per cent. 3. Thoracoplasty failure, 16 per cent. 4. Giant Cavity, 12 per cent. 5. Basal Cavity, 7 per cent. 6. Bronchostenosis, 5 per cent. 7. Alternative to thoracoplasty, 4 per cent.

ROUTINE

All patients had preoperative bronchography and bronchoscopy for the diagnosis and location of any tuberculous bronchitis or bronchiectasis. In addition to the usual preoperative preparation of any surgical patient, they received streptomycin for one week preoperative and two weeks postoperative, in a dosage of two grams per day until February, 1948, when the dose was decreased to one gram per day. Recently, there has been a change to dihydrostreptomycin, due to its lower incidence of toxicity.[7] Penicillin was also given for two days preoperative and two weeks postoperative in a dosage of 300,000 units per day. In addition, penicillin and streptomycin were placed in the thoracic cavity at the time of surgery, and in the cases of pneumonectomy were instilled into the thoracic cavity for two weeks. Streptomycin and penicillin were continued

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longer than two weeks postoperative in a few cases, where it was deemed necessary. Whole blood was given through an ankle cannula, during surgery and in the postoperative period, for adequate replacement therapy. Endotracheal anesthesia of cyclopropane, ether, oxygen and curare were administered by a medical anesthetist.

Pneumonectomy, lobectomy and segmental resections were carried out using individual hilar dissection and ligation technic. Bronchoscopy was performed at the completion of surgery. A corrective limited thoracoplasty was performed six to ten weeks after the resection. After resection, the patients are placed on three to nine months of bed rest, and then transferred for rehabilitation.

RESULTS

There were seventeen pneumonectomies and forty-one lobectomies and segmental resections performed on fifty-seven patients. There have been two patients to expire during the first week following surgery. One of these deaths, on the second postoperative day, was due to a blood embolus in the left middle cerebral artery, and the other death, on the sixth postoperative day, was due to a tuberculous meningitis. There have been six late deaths, ranging from two to four months postoperative: one was due to a metastatic non-tuberculous brain abscess; one pulmonary insufficiency; one following a corrective thoracoplasty; and the remaining three deaths were due to progression of the disease, following contralateral spread or fistula and mixed tuberculous empyema. This gives an over-all mortality rate of 13.7 per cent. The morbidity rate was: contralateral spread 8.6 per cent; fistula and empyema, 5 per cent; ipselateral atelectasis, 7 per cent; and troublesome dyspnea, 3.5 per cent. Of the surviving patients, 90 per cent have a negative sputum; this has been confirmed by numerous cultures in 52 per cent, and by guinea pig inoculation in 26 per cent. Of the forty-nine surviving patients, forty-eight are clinically well, and one is living with a fistula, empyema and contralateral spread. Seventy-five per cent of the patients have been followed six to seventeen months, and 25 per cent have been followed two to six months.

COMMENT

We feel that these results (comparable to those of others), in this group of patients with previous collapse therapy failure, are quite promising. Several factors contribute to this lowered mortality and morbidity, but the outstanding one, is the protective value of streptomycin.

It has been definitely shown that the tubercle bacillus develops resistance to streptomycin; this noticeable resistance occurs frequently after forty-two days, and is present in around 70 per cent of the cases after 120 days of therapy.[4,8] There have been no reports of resistant tubercle bacilli after a three weeks' course of the drug. The use of streptomycin as a protective agent in pulmonary resection for tuberculosis is one of its definite indications, and becomes obvious when reviewing results of resection with and without its protective use. The other indications for streptomycin in tuberculosis have been fairly well established: Acute bronchopneumonia, tuberculosis with severe symptoms, acute bronchogenic spread, and chronic disseminated finely nodular tuberculosis without large confluent areas of destructive disease; tuberculous lesions of the mucous membranes; tuberculous sinuses and fistulae; genito-urinary tuberculosis; tuberculosis of the bone, joint and cartilage; tuberculous meningitis; miliary tuberculosis; perhaps tuberculous lymphadenitis; and tuberculous peritonitis, and pericarditis.[7] In these instances to be of much value, the drug must be given in periods varying from 42 to 120 days; thus it is obvious at once that to be of value, when used in definite indications, resistance to the drug is going to be developed in a good many patients. As past experience has shown, many of these same patients will eventually become various types of collapse therapy failures, and pulmonary resection will be proposed as therapy for them. If these patients have resistant tubercle bacilli, the surgery will have to be performed without any effective streptomycin protection—with the accompanying high morbidity and mortality rate of the pre-streptomycin era. In administering streptomycin, it should be given with the over-all plan of attack on the disease in mind; the period of chemotherapy worked into an over-all plan of treatment which frequently will include surgical procedures of some type.

Thus it becomes of paramount importance for the physician treating tuberculous patients, to use considerable discretion in the administration of streptomycin, remembering (until the ideal drug is discovered), the indiscriminate use of streptomycin may well cost the patient a chance of cure at a later date or even his very life.

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A Pre-Sacral Dermoid in a Young Adult Male

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CONGENITAL anomalies of the sacral region are common. Pilonidal cysts and sinuses have been observed by Ravdin and Johnson[5] in 2 to 5 per cent of young adult males, although the incidence is much lower in females. Pre-sacral dermoids, on the other hand, are rare and have been found almost exclusively in the female.

The derivation of dermoid cysts ventral to the sacrum is uncertain. They are ectodermal in origin and may arise from a variety of fetal structures in this area. They are lined with epithelium, frequently contain hair and sebaceous material, and may contain other ectodermal derivatives. They probably originate by inclusion of portions of ectoderm in faulty coalescence of cutaneous surfaces during embryonic life, and are sometimes called sequestration dermoids.

Ewing[1] postulates their possible origin in vestiges of the neurenteric canal, the post-anal gut, or the proctodeal membrane. The embryological aspects have been discussed in detail by Lahey and Eckerson,[2] Whitaker and Pemberton,[7] and several others and will not be considered further here.

Whitaker and Pemberton[7] reported nine cases of pre-sacral dermoids occurring at the Mayo Clinic from 1922 to 1936 inclusive, with a frequency of about one case in 97,000 registrations. All nine cases occurred in females. Landsman[3] (1929) reported a case of an intrapelvic dermoid pointing into the rectum occurring in a male. At the 46th annual meeting of the American Proctologic Society (June, 1947) Schofield[6] reported an ischioanal dermoid also occurring in a male. These are the only two other cases on record of pre-sacral dermoids occurring in the male sex.

The case reported here is of interest not only because of its rarity but because of the insidious development of a carcinoma of the sigmoid during observation and treatment for the pre-sacral dermoid.

CASE REPORT

A 31-year-old white male entered the hospital on February 22, 1947, with fever for five days. Fullness in the rectum had been noted for several weeks with some pain and discomfort. Five days previous to his admission a proctosigmoidoscopic examination had been done, and a diagnosis of a "submucosal abscess" was made. A fluctuant mass was palpated posterior to the rectum in the hollow of the sacrum, and appeared to be about the size of a large lemon. The mass was aspirated with a needle and purulent material was obtained. Microscopic examination and culture of this material was negative for tubercle bacilli. The cystic mass was then incised through a proctoscope. The fullness and the discomfort in the rectum disappeared but fever without chills persisted daily. A primary tuberculous complex had been noted 10 to 12 years previously but recovery apparently had been spontaneous.

Five years previously hematuria had occurred. A cystoscopic examination was done at that time but the cause of the hematuria was not determined. Rectal bleeding had been slight for the past five years and had been attributed to hemorrhoids.

Physical examination revealed an asthenic, young white male appearing chronically ill. Digital examination of the rectum disclosed an external thrombosed hemorrhoid on the left. The anal sphincter tone was good. The prostate was not enlarged and no masses were palpable at that time.

Tuberculosis was suspected and a detailed examination of the various systems was made. A chest X-ray was negative and cystoscopic examination and retrograde pyelograms were also negative. A barium enema X-ray disclosed no pathosis in the colon.

Laboratory studies revealed a corrected sedimentation rate of 24 mm. in one hour. The red blood count was 4,060,000 with 10.8 gms. Hg., and the white blood count was 8,500 with a normal distribution. Urinalysis was negative and a blood culture was also negative. Gastric washings were negative for tubercle bacilli. The Widal test showed positive agglutination in dilution of 1:320. Undulant fever serology with Brucella abortus was negative. Feces examination was not significant.

A proctosigmoidoscopic examination was repeated to 25 cm. disclosing only the scar of a draining sinus at 12 cm. with some fullness posterior to the rectum in this area. The cavity was reopened and the temperature returned to normal within 24 hours. It was decided that more extensive drainage was indicated, so the sinus opening was enlarged with a cautery knife and the cavity packed with gauze. The temperature remained normal and the patient was discharged four days later. In the next three months the rectal opening to the cystic cavity became occluded several times and necessitated surgical drainage.

In July, 1947, the patient's family became dissatisfied with his progress and prevailed upon

Submitted January 24, 1949.

The Authors

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● Dr. Fuzy, Youngstown, Ohio, is a graduate of University of Buffalo School of Medicine, 1918; fellow, American College of Surgeons; chief, proctologic department, Youngstown Hospital.

the family doctor to send him to a well-known clinic in a neighboring city.

The cavity was again unroofed and at this time a large ball of hair measuring 7x5x5 cm. was removed. Through a proctoscope the inner wall of the cyst was examined and hair was seen growing from the wall. A diagnosis of pre-sacral dermoid was made.

Because of the opening into the rectum it was thought unwise to drain the cyst to the outside, as this would result in a rectal fistula and

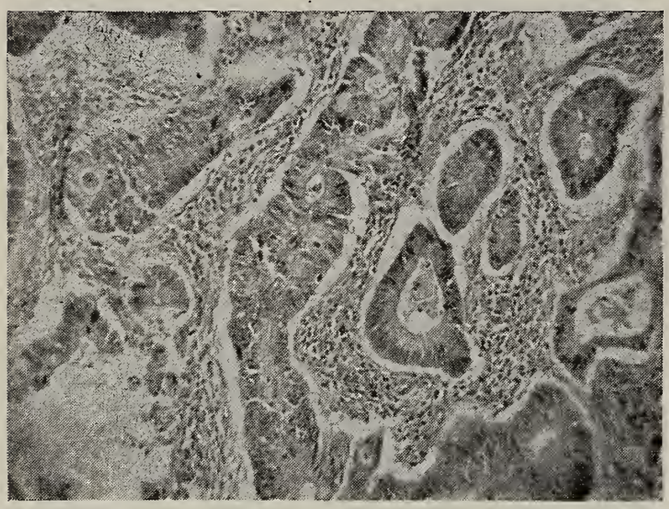


Figure 1. Adenocarcinoma of the rectum in a male with a pre-sacral dermoid cyst.

would be more annoying than the present condition. A mushroom catheter was inserted into the cyst to keep it open and draining until an epithelialized tract between the cyst and the rectum should form.

The cyst was examined intermittently and the tract dilated on several occasions. His last visit to the neighboring clinic for treatment was on December 19, 1947.

Ten days later (December 29, 1947) the patient was readmitted to the North Unit of the Youngstown Hospital Association with an acute bowel obstruction. Dull pain had been present in the left lower quadrant for two weeks. No diarrhea had been experienced but bright red blood and some mucus had been noticed on several occasions. In the week previous to admission no bowel movements had occurred. Repeated enemas had been ineffective and so castor oil had been taken. The crampy abdominal pains became severe and abdominal distention increased.

Physical examination disclosed a markedly distended tender abdomen. Peristaltic rushes were distinctly audible. Abdominal palpation was unsatisfactory due to the marked distention and tenderness but the entire abdomen was tympanitic. A flat plate of the abdomen disclosed considerable dilatation of the ascending and descending colon by gas. An X-ray diagnosis of obstruction of the sigmoid was made.

Sigmoidoscopic examination disclosed the presacral dermoid draining into the rectum at 12 cm. An obstructive lesion having the appearance of an neoplasm was noted at 19 cm. A biopsy taken for microscopic examination disclosed a polypoid adenocarcinoma of the sigmoid.

Dehydration was corrected with saline and blood transfusions and the abdomen was opened through an upper right rectus incision, and a transverse colostomy was done. Several large nodules were present in the omentum at the time of operation. These were excised and proved to be metastatic adenocarcinoma. The obstruction was relieved, the abdomen became flat, and the general condition greatly improved.

On the sixteenth postoperative day the abdomen was again opened. Inspection disclosed a small annular carcinoma of the sigmoid that was firmly adherant to the base of the small bowel mesentery and to the posterior abdominal wall and was in close approximation to the left ureter and the lumbar spine. It was freed with difficulty by blunt dissection but considerable mesenteric hemorrhage occurred. The hemorrhage was controlled, the tumor resected, and a colostomy was established. The condition of the patient did not permit a primary anastomosis. His postoperative condition was poor and in spite of the administration of blood and plasma, he went into shock and died five hours postoperatively.

The surgical specimen showed an almost completely annular tumor involving all layers of the bowel and completely obstructing the lumen. The microscopic sections (Figure 1) revealed widespread infiltration of the bowel wall with atypical glandular structures lined by pleomorphic cells. Large acini were seen distended with mucin. Infiltration into the serosa was widespread. A diagnosis of mucinous adenocarcinoma of the sigmoid was made.

AUTOPSY FINDINGS

When the abdominal cavity was opened, a large amount of blood was seen and it appeared that the patient had died of postoperative hemorrhage. The heart showed moderate hypertrophy. There was severe atelectasis of both lungs. Acute and chronic peritonitis was present. Focal areas of talcum powder granulomata were noted on the small bowel. The liver showed considerable involvement with metastatic papillary mucinous adenocarcinoma and also some pericholangitis. The mesenteric lymph nodes also showed metastatic adenocarcinoma. There was a stricture of the left ureter with moderate hydroureter and hydronephrosis. The cause of the stricture was



Figure 2. Pre-sacral dermoid with extensive lymphocytic infiltration.

probably the pressure of the overlying tumor, although actual tumor involvement of the ureter could not be proven.

Posterior to the rectum, in the hollow of the sacrum, a cyst was found measuring 9.5x6x6.5 cm. in diameter. The cyst was lined with a thick, tough, pale gray membrane from which projected numerous hairs. A mushroom catheter connected the cyst and the rectum 12 cm. above the anus. Microscopic examination of the cyst (Figure 2)

revealed a lining membrane of atrophic squamous epithelium beneath which was extensive lymphocytic infiltration with a vascular fibrous stroma. In the submucosa there were large histiocytes laden with golden brown pigment.

DISCUSSION

The diagnosis of a pre-sacral dermoid is frequently entertained only after repeated futile attempts have been made to drain an "abscess" of the pelvis. In the case here presented the diagnosis of a pre-sacral dermoid was not made until hair was discovered in the sac. It was then too late to do a clean-cut primary excision of the cyst and adequate drainage was the therapeutic aim.

When first examined in February, 1947, the patient was sigmoidoscoped to 24 cm. and a few days later to 25 cm, and no neoplasm was observed. Examination at a later date here and at the other clinic failed to reveal any growth although the extent of their examination is not known. Eleven months after the first visit, however, the patient had a completely obstructing carcinoma of the sigmoid that was almost completely annular. It is quite possible, although hardly understandable, that this tumor was overlooked on several examinations by competent proctologists, both here and at the prominent neighboring clinic. It is also possible that the rate of growth of the tumor in an individual of 31 years was of such rapidity that it progressed from oblivion to obstruction in the last 5 or 6 months of the patient's life, during which time proctosigmoidoscopic examination above the dermoid cyst (at 12 cm.) probably was not done.

Joseph Mathews[4] in 1895, said, "It behooves us as surgeons occasionally to take a breathing spell and look backward over the field, if not over the dead." In the treatment of any chronic disease condition, a "look backward" will at times alter the future treatment in light of newer findings.

As stated previously, pre-sacral dermoids are rare, and especially so in the male. Carcinoma of the sigmoid, on the other hand, is not rare, although not too common in an individual of 32 years of age. The probability that these two conditions would exist simultaneously by chance alone is exceedingly unlikely. We were unable to demonstrate, however (at surgery or at autopsy), any causative relationship between these two conditions.

SUMMARY

A 31-year-old male with a pre-sacral dermoid cyst developed a carcinoma of the sigmoid colon while under treatment and observation for the dermoid cyst. A review of the literature shows the rarity of pre-sacral dermoid cysts in males. No etiologic relationship was disclosed between the two conditions.

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Aureomycin in Various Infections

A new antibiotic, in order to take its place alongside those which have become established in practice, must have one or more of the following attributes:

1. It should be easily administered.

2. It should be active in diseases for which there is no satisfactory remedy, or it should be more effective than the drugs formerly available.

3. It should have a wider field of action than other antibiotics.

4. Its toxicity should be low.

Aureomycin shows promise of meeting all of these criteria. 1. Oral administration will produce constant and therapeutically active concentrations of the antibiotic in the blood. 2. It shortens the course of several rickettsial diseases, of some cases, at least, of primary atypical pneumonia, and perhaps in cases of infectious mononucleosis, all diseases for which there has been previously no specific remedy. It is more effective in brucellosis than the combination of streptomycin and sulfadiazine which has previously been the regimen of choice in this disease; it is apparently more effective in lymphopathia venereum than the sulfonamides, and in some cases it has proved to give better results than penicillin in severe staphylococcal infections. 3. Its field of action is wider than that of penicillin, since it acts not only against infections caused by the cocci but also in brucellosis and the rickettsial diseases, several infections caused by viruses and of unknown etiology, and to some extent against infections caused by gram-negative bacilli. 4. No serious toxic reactions have been reported, although the nausea and vomiting which are sometimes present are annoying and occasionally interfere with the adjustment of therapeutic concentrations in the blood. They are apparently due to an impurity and not to the aureomycin itself, since all lots of aureomycin do not have the same emetic effect. Consequently it is extremely likely that the manufacturers will soon be able to eliminate the substance which causes these disagreeable reactions.—Dowling, et. al., Medical Annals of the District of Columbia, Vol. XVIII, No. 7, July, 1949.

Toxic Reaction to Metycaine

ANSEL WOODBURN, M.D.

A WOMAN, aged 36, had been operated on about a year before for a toxic goiter. Since her operation, menstruation was excessive in amount and prolonged. For this condition, she was curetted without benefit, and given numerous endocrine and other injections, the best result being obtained with Menadione 5 mg. in oil intramuscularly.

On December 16, 1947, she was to be given her Menadione injection. Since she complained of pain from this injection, 0.5 cc. of 1 per cent Metycaine (without epinephrine) was given into the thigh muscle. The syringe barrel was aspirated before injection of the Metycaine, and no blood was obtained. In two or three minutes the Menadione was injected without pain.

Within a few minutes she complained, "I feel so tired," and yawned several times. At the same time, severe itching occurred (without any visible skin lesion); pallor of face and lips; and a muttering incoherence of thought and speech like an acute alcoholic intoxication. Pulse was rapid but regular, no cyanosis, no twitching of muscles.

Because of the itching, epinephrine was considered as treatment to be rejected because of the previous goiter. As the vital functions were not seriously impaired, and there was no marked stimulation nor depression of the central nervous system, no treatment was given, watchful observation being carried out.

During the entire reaction period, there was a tendency to be very disagreeable and antagonistic, as manifested often in acute alcoholism.

The patient was not able to leave my office from 3 p.m., until about 8 p.m. That night and the next day, she slept almost continuously, but could be aroused easily. This sedative characteristic would suggest a possibility of some closely related compound being developed as a very potent, long-lasting hypnotic.

Subsequent skin test to procaine was negative, and it has been used repeatedly without toxic manifestation.

On April 8, 1948, 0.05 cc. of 1 per cent Metycaine was injected intradermally on the forearm at 3:27 p.m. At 3:34 a ring of erythema was developing around the wheal, and at the same time, headache developed, she became shaky, hot then cold, and mentally confused, which confusion progressed to sleepiness. A tourniquet was applied to the forearm, the wheal was incised and allowed to drain. Recovery ensued in about 15 minutes.

Submitted March 12, 1949.

The Author

● **Dr. Woodburn, Urbana, Ohio, is a graduate of University of Cincinnati College of Medicine, 1921; member, American Academy of General Practice; member of staff, Champaign County Hospital; and a member courtesy staff, Springfield City Hospital, Springfield.**

This case represents an unwelcome and inconvenient, but not dangerous, reaction to a local anesthetic.

ADDENDA

The above report was submitted to the Medical Department of the Eli Lilly Company. The following letter was received from them:

● ● ●

April 19, 1948

Dear Doctor Woodburn:

We have received your interesting report of April 13 concerning one of your patients who had a reaction following the administration of 'Metycaine' (Gamma- (2-methyl-piperidino) propyl Benzoate Hydrochloride, Lilly). We note that the original reaction followed the administration of 0.5 cc. of 1 per cent 'Metycaine' solution. This represents 5 mg. of the drug. The skin test was done with .05 cc. of 1 per cent 'Metycaine' and, therefore, contained 0.5 mg. of the drug.

We have not previously heard of a reaction of this sort following such a small dose of 'Metycaine.' You are doubtless aware that doses of 100 to 200 mg. of 'Metycaine' have been used commonly for spinal anesthesia without untoward effect. The usual initial dose of 'Metycaine' in continuous caudal anesthesia is 450 mg. We have heard of a single dose of 1,800 mg. without side-effects. While no articles on intravenous administration of 'Metycaine' have been published, we know that quantities of 500 to 1,000 mg. have been given intravenously in the course of an hour or two without incident.

It is quite apparent, therefore, that this patient's reaction represents an idiosyncrasy to 'Metycaine.' The itching which the patient reported suggests that the reaction may be fundamentally allergic, as does the local reaction about the intradermal injection. It seems to us quite remarkable that an intradermal dose of 0.5 mg. of 'Metycaine' should have been followed by such pronounced constitutional symptoms. As we said before, we have not previously heard of this type of reaction to such a small dose. It would appear that idiosyncrasy to 'Metycaine' is very uncommon. We know that a great many dentists who are allergic to procaine can use 'Metycaine' without untoward effect.

Yours very truly,
ELI LILLY AND COMPANY
(Signed)
J. M. Maas, M.D.
Medical Department

The Management of Appendiceal Abscesses

WILLIAM P. MONTANUS, M.D.

DURING the past decade there obviously has been a most satisfactory, nationwide, improvement in the death rate of appendicitis. Although the elapsed time from onset until treatment has been significantly decreased in some instances, public education has not been the only factor in lowering the mortality. The increased use of blood transfusions and the employment of the sulpha and antibiotic drugs are, perhaps, more important. The increased popularity of the McBurney incision may also be a factor.

There has been no controversy, of course, concerning the management of the uncomplicated phase of the disease, and even in the instances of diffuse or spreading peritonitis, surgeons are in considerable agreement. There may be some variation of opinion regarding the course to be followed in the later phases of this condition. However, the management of appendiceal abscess is still the subject of a rather wide divergence of viewpoint. Some surgeons operate on all abscesses after suitable preparation, while, on the other hand, there are those who make every effort to be conservative in expectation of avoiding early surgery. I should like to make a plea, if not for more conservatism, then certainly for a more cautious approach to this problem.

In a five-year survey made at the Cincinnati General Hospital in 1939, it was found that the mortality rate in 129 patients having appendiceal abscess was approximately 10 per cent. This was somewhat higher than should have been expected, and in reviewing the result of treatment at other institutions, it was apparent that those clinics having a more conservative approach were rewarded by a low death rate in patients with appendiceal abscesses. Lehman and Parker,[1] at the University of Virginia, reported a mortality rate of only 1.5 per cent in a group of patients treated conservatively. I could not avoid the feeling that a more cautious approach might have resulted in a decrease of mortality in the patients surveyed by us. Now with such effective aids as penicillin and streptomycin have proved to be, I believe there is even better reason for a more cautious type of treatment.

Perhaps at this point I should explain that I am not of the opinion that drainage may always be avoided. In most cases I have found it quite necessary and eventually unavoidable.

Presented before the Section on Surgery at the Annual Meeting of the Ohio State Medical Association, Columbus, April 19, 1949.

The Author

● Dr. Montanus, Springfield, Ohio, is a graduate of University of Cincinnati College of Medicine, 1935; diplomate, American Board of Surgery; fellow, American College of Surgeons; on active staff, Springfield City Hospital.

However, delay for intensive supportive treatment will be time well spent, and will result in spontaneous disappearance of the abscess in some instances. Many of these "so-called" appendiceal abscesses contain little pus, the mass consisting mainly of omentum and loops of bowel walling off the perforated appendix. With adequate treatment, many will undergo complete resolution without surgery, while others may rupture spontaneously into the bowel and thus drain themselves. The latter, of course, is not an ideal situation.

That penicillin in massive doses is decidedly helpful seems beyond question. In 1946, George Crile, Jr.,[2] reported that in a series of patients with appendiceal peritonitis including 33 cases with palpable masses, no drainage was necessary when large doses of penicillin were administered.

Favin and Romack,[3] working on experimental animals, found that the injection of penicillin in closed appendix loops, resulted in 100 per cent survival compared to 90 per cent deaths in the control series. The experimental results of Murphy[4] and of Rothenberg[5] were similar.

TREATMENT

Although there may be some dissenting opinion, most will agree that the administration of streptomycin is also a distinct advantage. Silvani[6] and his colleagues found that this drug was of value both in patients and in experimental animals, although it did not seem to alter the intestinal flora of laboratory animals to any significant degree. Both penicillin and streptomycin undoubtedly have given us additional weapons and a sounder hope that we may avoid forced early drainage and further decrease the death rate from appendiceal abscess.

The supportive or adjunctive management of these cases is too generally known and practiced to be of great interest here, but I should like to review it now. After admission to the hospital the patient is immediately denied all solid food by mouth, although many may safely be allowed fluids. Those with evidence of abdomi-

nal distention are placed on continuous gastric or intestinal suction and supported adequately by intravenous fluid, electrolytes, vitamins and protein. In many, if not in most instances, small blood transfusions are given daily or on alternate days. Penicillin, units 100,000, is given immediately and continued at three-hour intervals. In addition, 250,000 units of streptomycin are administered with the same frequency. If, after a period of from twelve to twenty-four hours, the temperature and white blood cell count decrease and the pain and tenderness are less marked, the treatment is continued. Many of these abscesses will gradually decrease in size and disappear without surgical intervention. On the other hand, if at the end of the above period the mass seems tense and the pain and tenderness, along with the fever and white count do not present definite evidence of improvement, surgical drainage is provided. When operating upon these patients, extreme caution should be exercised so that contamination of the uninvolved portion of the peritoneal cavity may be avoided. The use of a rather lateral McBurney type of incision is recommended and the surgeon should carefully deflect the peritoneum to provide an exposure permitting direct entry into the abscess cavity without transversing uninvolved peritoneum. This site will frequently be posterolateral. However, when the occasion demands, there should be no hesitancy in changing either the type or location of the incision. The finger, I believe, will prove to be a much more effective and a safer instrument than the scissors or hemostat in draining the abscess.

Following either conservative or surgical treatment, the patient must always be told that his appendix has not been removed. Thus we may avoid some future confusion and danger if contact with the patient should be lost.

What happens to the diseased appendix following successful treatment of the abscess? Some become obliterated and may not be the source of future disease. Others again become inflamed. Recently I have performed emergency operations upon three patients, all of whom had undergone previous drainage of an appendiceal abscess. One of these had reperforated the appendix only two months after drainage, and another had an acute, gangrenous recurrence after five years. In the remaining case, a gangrenous appendix was removed eighteen years after the original drainage operation. As it is impossible to foresee what may happen, it is advisable to remove all of these diseased organs in about four months. Regarding too early operation, a word of caution is in order. In one such instance a small residual abscess was encountered near the tip of the appendix. This patient died as a result of generalized peritonitis. With the employment of sulpha and antibiotic drugs, I believe removal of the appendix may be safely done after about four months have elapsed.

DECREASE IN INCIDENCE AND MORTALITY

One may note that some recent articles mention that the appendix has been removed at operations for drainage of appendiceal abscesses. Perhaps some of us have been over-confident. No matter how effective modern drugs may be, we should not be misled into violation of established surgical principles.

We are now seeing fewer appendiceal abscesses than ever before and this fact is very encouraging. At the Cincinnati General Hospital 28.3 per cent of all acute cases of appendicitis treated from 1915 to 1933 had localized abscesses. In the period 1934 to 1938 the number had decreased to 14 per cent and in 1939 to 1943 to 10.7 per cent. At the same institution the mortality due to appendiceal abscesses has decreased from 11.4 per cent in 1915-1933 to 4.3 per cent in the period from 1939 to 1943. We may safely expect a still greater improvement during the present period, and I believe that a more cautious and expectant type of management could be a factor in this improvement. This, of course, would be of less consequence than the influence of antibiotic drugs.

My recent experience with this disease, fortunately, has not been great. It consists of only five patients of a total of 100 with acute appendicitis. In four of these, an expectant course of treatment was attempted. Operation was avoided in only one instance. However, in the cases of two of the four patients who were drained, there was some contamination of the uninvolved portion of the abdomen due to a break in the abscess wall incident to the trauma of operation. If we had delayed operation for a longer period and obtained better walling off of the infection, perhaps this spread of infection would not have occurred. All of these patients survived.

INFLUENCE OF RACE, AGE, ETC.

The influence of such factors as race and age is of considerable interest and may modify some of our concepts and practices. Patients over sixty have less ability to localize infections than have younger persons. In this group, one should be very concerned about delaying drainage over any long period of time. Occasionally a spontaneous rupture into the free peritoneal cavity may occur and these frequently result in death. Apparently, appendicitis is a more serious disease in Negroes than white people. This may be due to greater delay in hospitalization and the more frequent use of cathartics among Negroes, but, in addition, there may be a factor of relationship between infection and resistance. Whatever the explanation, we

should be more careful in regard to delaying operation in members of the Negro race.

The surgeon must also consider other factors which may indicate less resistance to abdominal infections. It is not unusual to encounter patients with perforated appendices whose white cell count is normal or below normal. This, in all probability, indicates lack of resistance, and may mean that the patient is unable to safely wall off an infection of appendiceal origin. In this situation excessive delay in operation may be dangerous.

Perhaps there are many other factors influencing the severity of appendiceal infections and the patient's ability to control them. Such things may be dietary habits, occupation or economic circumstances. When comparing the mortality from appendicitis computed at large charity institutions with the much better results reported from certain private institutions, one cannot avoid the conviction that such factors are operative.

However, in general, it may be said safely that the outlook for an appreciable decrease in appendicitis mortality is excellent. The chief factor may well be the antibiotic drugs.

CONCLUSION

In this brief article, I have attempted to describe a conservative, or more properly, a cautious approach to the problem of treating abscesses secondary to appendicitis. If such a course is more widely adopted, it is my opinion that the mortality rate in this disease will be further reduced.

That great strides have been made in the reduction of the number of deaths due to appendicitis, is beyond doubt. The chief factor may be the use of antibiotic and sulpha drugs, but, in addition, more careful surgical technique and a better understanding of the problem of peritoneal infection are important factors.

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Skin eruptions following Pyribenzamine have been reported by Harris and Shure, and by Epstein. Eczematoid and pityriasis rosea type eruptions cleared with the discontinuation of the drug, and recurred on its administration.—Brodkey, Neb. State Med. Jour., Vol. 34, No. 9, Sept., 1949.

KEEPING UP WITH MEDICINE

• THERE is beginning a trend in medical education towards a proper balance between the teaching of the physical and the social factors in disease.

* * *

• RECENTLY Fontaine and his co-workers have found that an antibiotic isolated from young tomato plants and called "Tomatin" has an inhibitory action on cultures of H. capsulatum. We await its application to histoplasmosis for which penicillin, the sulfonamides, potassium iodide, arsphenamines, quinquevalent antimonials and radiation therapy have all proved valueless.

* * *

• THERE must be something really wrong with a system of education which cannot meet the demand either for qualitative or quantitative service. Yet, in spite of all our boasted progress in many hospitals, entire floors are closed because of a lack of nurses.

* * *

• GRAM-NEGATIVE bacilli found in dental caries can release an enzyme-sulphatase. Sulphatase in turn can release sulphuric acid from mucotin sulphuric acid in the enamel protein and chondroitin sulphuric acid from the dentive. This sulphuric acid can then attack the calcium salts of both the enamel and dentive thus causing caries.

* * *

• TETRAETHLYTHIURAM disulfide, "Antabus," the anti-alcohol drug, acts by depressing the oxidation of the acetaldehyde.

* * *

• TREATMENT of coeliac disease with injection of liver extracts and vitamin B have proved useful, particularly during the acute phases of the disease; but only in addition to dietary measures.

* * *

• THE toxic factor in flour bleached wtih nitrogen trichloride has been isolated in crystalline form.

* * *

• THE contrast has often been pointed out between the sanitary precautions we take with our water supply and those of our air.

* * *

• ALTHOUGH the problems of chronic illness and geriatrics are not identical, they do overlap and have many things in common.

* * *

• FROM January, 1942, to June, 1945, there were about 586,518 admissions to Army Hospitals who were listed as psychoneuroses. During the same period, there were 256,134 individuals discharged from the Army with a diagnosis of psychoneurosis. This was about five times as many as in World War I.—J. F.

Acute Cardiorespiratory Failure: Requirements for Successful Resuscitation. I. Introduction*

CLAUDE S. BECK, M. D.

THE purpose of this symposium is to establish a practical program for resuscitation. These presentations* are by a group of experts in the field. The physiology is presented by an authority.

I should like to refer to the type of condition in which resuscitation can be applied. Resuscitation has been carried out under conditions outside the hospital but in our discussion we refer only to patients who are in the hospital. Resuscitation does not require the facilities of the operating room but success is more likely if it is carried out in the operating room where the heart can be exposed without delay.

The one point then is that the patient is in the hospital and preferably in an operating room. The second point concerns the type of condition that brings the patient into the hospital. The only statement that can be made about this is that there is no relationship between the condition upon admission and the subsequent need for resuscitation. The patient who can be successfully resuscitated has a good heart and a good pair of lungs. There is no disease of the oxygen system. Success is not likely to occur in the presence of coronary artery disease, valvular disease of the heart, myocarditis, pneumonia, anemia, sepsis, etc. The breakdown in the oxygen system is reversible. Something happens to the oxygen system. The breathing stops or the heart stops. This may occur from the effect of a drug or from an anesthetic. It may occur as a reflex during operation. It may occur without any recognizable cause.

Once the oxygen system breaks down the surgeon and the anesthestist have five minutes or less to get it started again. The dead line is approximately five minutes. If the oxygen system is broken for a longer period of time then successful resuscitation is usually not possible. This period of anoxia determines success or failure. Therefore, we surgeons and anesthetists must be prepared to act within a certain time requirement.

Reestablishment of the oxygen system:—This is done by getting oxygen into the lungs and by distributing the oxygen from the lungs to the brain. There are two things that have to be done. One is to introduce a tube into the trachea and inflate the lungs with oxygen. The other is to get your hand on the heart and massage it. The lungs can be inflated by squeezing a bag full of oxygen or by the use of a respirator. A respirator does this better than the hands. Mr. Rand and Mr. Wolfe are presenting a new respirator which I have found to be very satisfactory. To expose the heart an incision is made over the precordium between the 4th and 5th ribs. The costal cartilages of these ribs are cut across and a retractor is placed in the chest wall. The heart is squeezed together a few times and the pericardium is opened. The heart is massaged by placing the fingers under the venticles and squeezing the heart against the sterum or the thumb. The rate is 40 to 60 per minute. There is no special method for doing this except to bear in mind that both ventricles should be emptied of blood and then allowed to fill. We believed that it might be possible to make a mechanical device that would empty the heart more effectively than massage by hand. This was not accomplished. However, the suction cups presented by Mr. Rand and Mr. Wolfe are an aid in filling the heart. By means of these suction cups the heart can be pulled apart, so to speak, and made to fill more rapidly. The rate of massage can be increased when these cups are used and it is our belief that the heart becomes pinker and that the myocardium is better oxygenated.

Once the oxygen system has been reestablished, time can be taken for restoring the heart beat. There is no hurry about this. Electrodes should be placed on arms and legs for an electrocardiogram. One can get valuable information from this.

If the heart is in standstill, massage and a little epinephrine are effective in restoring the normal beat. One-half cubic centimeter of epinephrine diluted with 10 cc. of saline are injected into the right ventricle.

If ventricular fibrillation is present we inject 5 cc. of 1 per cent procaine into the right ventricle. Massage is continued. The ventricles are then shocked. If the fibrillation does not disappear, more procaine is used. This drug makes the heart flabby and less irritable. The shock should bring it to standstill. Epinephrine is then used and often a few more massages of the heart are needed. The heart then starts beating. Conditions must be right. The lungs must be well inflated and deflated. The heart must be pink. The heart beat can be restored.

*Discussion group during Annual Meeting of Ohio State Medical Association, Columbus, April 19-22, 1949. This series will begin in this issue with the balance of papers to be published in succeeding issues.

Non-Surgical Management of the Woman with Pelvic Cancer

LAWRENCE A. POMEROY, M. D.

AMONG the most common malignant tumors for which women consult their physicians are carcinoma of the uterine cervix, carcinoma of the uterine fundus and carcinoma of the ovary. In both types of uterine cancer, abnormal vaginal bleeding is usually the earliest symptom. It is unfortunate that when some women consult their physicians on account of excessive vaginal bleeding, they are told to return for examination after the bleeding has ceased. If the bleeding continues two or three weeks longer the time of diagnosis may be unduly delayed. The unwillingness of the physician to perform a pelvic examination during menstruation should not make him postpone for several weeks an examination that may reveal a malignant uterine tumor.

In my own series of carcinoma of the cervix, 790 patients treated by irradiation between 1919 and 1940, the percentage of five-year cures was 24.9 per cent. In the 94 patients treated between 1936 and 1940 the cure rate was 33.8 per cent.

The cure rate for the entire series varied from 63.6 per cent in Stage I (League of Nations Classification 1938) to 1.8 per cent in Stage IV. This emphasizes again the need for early diagnosis before the disease has spread beyond the limits of the cervix.

In all of my cases the tumor was classified according to cell differentiation but the results were practically the same in all grades of squamous cell carcinoma and also in adenocarcinoma.

In 34 cases of carcinoma of the uterine cervix, 30 years of age or younger, 20.9 per cent of five-year cures were obtained. The disease seems by no means hopeless in these younger women.

In carcinoma of the uterine fundus the problem is different. In these tumors the degree of cell differentiation may play a large part in determining the method of treatment. In general in the well-differentiated adenocarcinomas the main reliance is upon operation, possibly with intra-uterine radium application before operation. In the poorly differentiated adenocarcinomas (especially if there is any extension of the tumor beyond the uterus) the main reliance is on intra-uterine radium application and external X-irradiation. Because irradiation alone is more often used in the far advanced tumors and operation alone in the earlier tumors the results of treatment are difficult to evaluate. The following figures, taken from various clinics, are representative—

Surgical Treatment .....Five-Year Cures—50-70 per cent.

Irradiation Treatment .....Five-Year Cures—50-60 per cent

In carcinoma of the ovary the five-year cures usually range from 15 per cent to 30 per cent. Carcinoma of the ovary should be treated by operation (usually followed by external X-irradiation) if the tumor is removable. The ideal operation for this tumor is the removal of both ovaries and both tubes, together with the entire uterus. Removal of the one ovary grossly involved by the tumor is insufficient as the other ovary is involved (earlier or later) in many of these patients. Even in patients where there is no hope of cure the palliative effect of external X-irradiation, in suitable doses, is often surprising. Some patients with a large tumor filling the pelvis have been kept alive in comfort for over five years by repeated cycles of external X-irradiation.

Presented before the Section on Obstetrics and Gynecology at the Annual Meeting of the Ohio State Medical Association, Columbus, April 20, 1949.

The Author

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Rice Diet in Hypertension

Although the excellent results from this diet manifested by patients who follow it are not obtainable by any other medical regimen, many patients are not willing to follow it strictly, and only a slight addition of unauthorized food may prevent the desired result. Further, it is dangerous to prescribe the rice diet unless facilities are at hand for thorough laboratory control.—Clark, Felder & Chambers, Jrnl. Med. Assn. of Georgia, Vol. XXXVIII, No. 9, Sept., 1949.

Contact-Systemic Penicillin Reactions Associated with Oral and Nasal Inhalators

LAWRENCE C. GOLDBERG, M. D.

PENICILLIN is now being used by many physicians and patients as a panacea for too many ailments. Its indiscriminate use may lead to sensitivities of such unusual nature that its true practical value may be endangered. It appears that this could happen through the widespread and haphazard use of penicillin inhalators prescribed for upper respiratory infection, particularly "common colds."

In the last several weeks eight patients with penicillin reactions of both the contact and systemic type have been observed. Histories of these patients elicit the fact that they have been using dispolators, aerohalators and nebulizers. In all of these patients the reactions have been of the immediate type, but there does not appear any reason why they could not also develop delayed reactions. In one of these cases, a female patient presented a maculopapular and edematous reaction of the face which very readily could have been due to any type of contact particularly cosmetics. By chance, the patient, a doctor's secretary, volunteered the fact that twelve hours previously a detail salesman from a drug firm had suggested the use of a penicillin nebulizer for her mild sniffles. She stated that either because she was inept in the use of the nebulizer or because of the spray which came from her nostrils or her mouth a peculiar powder spray appeared all about her head. The skin reaction was confined entirely to her face with accentuation of erythema and edema about the lips and nares. She further stated that generalized pruritus was present. I am certain that without her common sense thinking it might have been days or I might never have come to the conclusion that her particular skin reaction came from this source.

The other reactions were as follows: Three of the erythemato-vesicular, trichophytid type, the most intense portions of the eruption being on the hands, feet and crural areas; one with widespread urticaria; three had the facial contact type; and one with generalized pruritus.

It occurs to me that all drug firms dispensing this form of penicillin, and because it may be used injudiciously, should warn or advise patients of the fact that penicillin reactions may occur from this usage of the drug. Furthermore, it is not the purpose of this report to state whether penicillin is of value to the treatment of the "common cold," but to call attention to physician and patient alike that this may be the cause of varying reactions of the contact-systemic type that go unnoticed. Although it has been emphasized that the induced sensitivity to penicillin is often temporary and that the drug is tolerated well on readministration, it is quite possible that repeated sensitivities from the mild reactions from the inhalator source, which might go undiagnosed, might lead to more serious situations. This has occurred in the past with other drugs particularly the sulfonamides and atabrin. Up to the present time the patient practically always received his penicillin by injection or by oral administration, and it does not appear too farfetched that he might never associate the mild skin reactions with his penicillin inhalations unless he was acquainted with such possibilities. If in the course of a few weeks in a limited practice such reactions are seen by one individual, it does not appear too impossible that such situations are occurring many, many times in one day throughout the country.

It is not a practical situation to patch test each and every individual before he takes penicillin, inasmuch as Peck, et al.,[1] reported only a 13.17 per cent positive reactions in 130 adults previously patch tested with penicillin. However, because of the declining cost of this drug and its dramatic results in indicated medical problems its use will become more and more common place resulting in probably a greater number of untoward reactions.

Patch tests have not been made routinely on these patients, inasmuch as severe generalized pruritus followed the application of a patch test done one week after a contact form of this reaction was seen. The patch test which was performed was similar to that described by Peck in which 2,000 units of penicillin (1.2 mg. of

Submitted May 5, 1949.

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crystalline penicillin G in 0.1 cc. of isotonic solution of sodium chloride) was used.

SUMMARY AND CONCLUSIONS

Eight cases of contact-systemic reactions to penicillin have been observed in a short period of time following the use of inhalators for "common colds." The contact reactions of the face when occurring in females could readily be mistaken for a cosmetic contact dermatitis. The systemic reactions included generalized pruritus, urticaria and erythemato-vesicular eruption of the trichophytid type. Inasmuch as there are no warnings or precautions on the inhalator instructions regarding the possibility of penicillin reactions from this source of therapy, patients fail to advise their physicians of such treatment. This in turn may lead the physician to false assumptions regarding skin or other visceral reactions which might have been induced by the penicillin. Repeated minimal sensitivity reactions to penicillin may lead to more serious reactions in the future and even to bacterial resistance. Drug companies should alert the public to untoward penicillin reactions by their legends and instructions where the use of penicillin cannot be completely controlled by the physician. In this way patients can better inform physicians as to possible drug reactions.

Note:—Since this paper was written 6 more similar cases have been seen, two of the contact type, two of the combined contact-systemic type, and two systemic reactions.

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Endocrine Problems of Adolescence

If the obesity is marked and in the case of the adolescence female there is failure to menstruate well past the expected age, then a low calory high protein diet, low dosage irradiation of the pituitary gland and ovaries, administration of estrogens, pituitary extracts and thyroid gland substance may be tried.

The diet is paramount in the treatment of obesity, although the correction of sedentary habits by gradually increasing exercises is helpful. The calories should be reduced to the point where persistent loss of weight occurs, which on the average will be between 500 and 1,000.

The protein content is high and in the form of lean meat, fish, eggs, cheese and milk. Two average portions of 5 per cent vegetables and four portions of 10 per cent fruits are allowed daily. One glass of skimmed milk or buttermilk with cottage cheese, supplies normal salts. No sugar and only one slice of bread. Eating at meals only. Vitamin concentrates should be prescribed. Water consumption should be curtailed to three pints per day.—E. Gardiner, M. D., Neb. State Med., Jour., Vol. 34, No. 10, Oct., 1949.

The Story Behind the Word: Some Interesting Origins of Medical Terms

Pituitary:—This term is derived from the Latin word "pituita" or phlegm which in turn came from the Greek "ptuo," I spit. It was so called because the ancients believed that this gland, situated at the lower side of the brain, secreted the mucous or phlegm which comes from the nostrils.

Pineal Gland:—This gland derived its name from the Latin word "pinus" or pine. The term was applied because the gland is shaped like the heart of a pine cone.

Yaws:—A term descriptive of the raspberry-like lesions of the disease. It is said to be an African dialect term, meaning raspberry.

Undulant Fever:—So called because of the wave-like or undulating type of fever characteristic of the disease. It is derived from the Latin word "unda" or wave and the name was given to the disease in 1897 by Hughes. The disease is now properly called Brucellosis in honor of Sir David Bruce, discoverer of the causative organism.

Appendicitis:—Interest in this disease was aroused in 1886 by Reginald Heber Fitz (1843-1913) of Boston, who was professor of medicine at Harvard. He first correctly interpreted the importance of the pathology and named the disease appendicitis from the Latin "appendere," "to hang to," plus "itis," "inflamation of."

Beriberi:—This is a Singhalese word which means "cannot." The people of Ceylon coined the name because the patient with beri-beri is so weak he cannot do anything at all.

Bunion:—A term of ancient origin said to come from the Danish word "bunke," a heap, or the Icelandic word "bunga" an elevation.

Expectorate, Expectorants:—Literally means "out of the chest" from the Greek "ex" or out and "pectus" or breast.

Gynecology:—Literally means the study of women. It is derived from the Greek word "gunachos," of a woman, and "logos," the study of.

Hyperpiesia:—This term was coined by Sir Clifford Allbutt (1903) who first accurately described the condition. It is derived from the Greek "hyper" or over and "piesia" or pressure.

Migraine:—This word is thought to be a corruption of the term "hemi-crania."

Mumps:—A term of uncertain origin. It is thought by some to come from the old English verb "to mump," meaning to sulk, or from the Scottish term mump meaning to speak indistinctly. There is also an allied Swiss term "mumpfeln which means to eat or speak with a full mouth.

—Harry Wain, M. D., Mansfield, Ohio.

Subluxation of the Head of the Radius in Children

EARL E. SMITH, M. D.

IN the past nine months, seven cases have been seen of injury to the elbow resulting from a sudden pull on the extended arm of an infant or young child by a parent or nurse.

One evening in March of 1948, a two-year-old male child was seen in which an injury to the right arm occurred when his father yanked him off the floor by the injured arm. The child screamed with pain and held his arm limply at the side and complained of pain on motion. The father reported over the phone that the elbow or wrist was injured and that he thought he felt something crack at the time of the injury. When seen, the patient presented a picture of the affected arm hanging motionless at the side, slightly flexed at the elbow, the hand being half-way between pronation and supination. There was no deformity at the wrist or elbow and only moderate tenderness over the head of the radius. Motion at the wrist and elbow was normal in all directions except supination, which gave rise to severe pain and a sense of obstruction. The arm was placed in a sling and the patient was seen at the office the next day where an X-ray was taken. There was no evidence of fracture or dislocation. The same physical findings were present, so a diagnosis of sprain was made. The parents were advised to keep the arm in a sling for a few days and if there was no improvement, orthopedic consultation would be obtained. Within thirty-six hours, the arm was completely recovered with no pain or impairment of function. Shortly, thereafter, Boyette and London[1] stressed the diagnosis and treatment of this condition and reviewed the literature. In retrospect, I am able to recall many such cases seen in the past, which were considered to be due to a sprain and treated with a sling with recovery, which in reality were cases of subluxation of the head of the radius.

The history, as a rule, is that of a sudden pull on the extended arm of the infant or child by picking the child up by one arm after a fall, pulling the child from under a table by one arm, lifting the child up stairs, or helping the child across the street and up the curb, etc. Many times the parent or nurse describes a clicking sensation felt at the wrist or elbow. As the patient frequently complains of pain in the wrist, the physician is often told over the telephone that the wrist is sprained or broken.

Submitted December 18, 1948.

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When seen, the patient, usually in the toddler age, presents a picture of the affected arm hanging motionless at the side, slightly flexed at the elbow, the hand being half-way between pronation and supination. Frequently it is difficult to localize the injury at either the wrist or elbow. In most instances, movements of the elbow and wrist are non-painful except for supination. This movement causes severe pain and resistance. Some evidence of tenderness in the region of the head of the radius is found. X-ray of the elbow and wrist reveals no pathology.

Boyette and London state that the proper manipulation for correction and reduction of the subluxation is simple. The elbow is flexed to about ninety degrees and one thumb of the operator is placed over the head of the radius, exerting moderate pressure upon it. The patient's hand and forearm is then forcibly supinated beyond the point of obstruction. If the operation has been successful the characteristic click of reduction can be heard or felt and the child will begin to use the arm. If the subluxation has been standing overnight, there will be some edema of the elbow joint and the child will not use the arm immediately in spite of reduction. In this type of case, it is best to place the arm at rest in a sling for a day or two.

Since March, six additional cases have been encountered, presenting the same type of history of injury, symptoms and physical findings. In all cases except one, reduction was obtained with the maneuver described by Boyette and others. An audible click was heard in all cases so reduced. Within a few moments, as soon as the patient found that he was able to use the elbow without pain, he began to utilize the in-

jured arm almost as freely as the uninjured one. The response to treatment is most dramatic to the parents and very gratifying to the physician.

CASE HISTORIES

Case I D. M., a two-year-old male. His mother jerked his extended arm two days before being seen at the office. He screamed with pain and the mother heard and felt a cracking sensation. He held his arm limply at his side and cried only when the arm was turned outward. In the office the arm was held limply at the side with the hand held mid-way between pronation and supination. Flexion and extension were non-painful, but attempts at supination resulted in marked pain. There was tenderness over the head of the radius. X-ray was negative. The subluxation was reduced with a palpable and audible click, within a few moments the child began to use the injured arm and appeared normal thereafter.

* * *

Case II M. R., a one-year-old female who was just beginning to walk, was on the verge of falling when her father grabbed her right arm and jerked her into an upright position. The child screamed with pain for several hours. The arm hung limply at the side. This occurred Sunday evening. Monday noon, the child was seen in the office presenting symptoms and signs, as mentioned, for subluxation of the head of the radius. X-ray was normal. Reduction was effected with the characteristic click and almost immediately the child began to use the arm and remained completely recovered.

* * *

Case III Baby X, an eight-month-old male infant was being lifted from the buggy by his hands when the mother's hold slipped and she pulled the baby by one hand. She heard and felt a crack; the baby screamed with pain and held the arm limply at the side. The baby was seen at home within an hour of the injury, the subluxation was reduced with the characteristic click felt and heard and the infant immediately began to use the arm and remained recovered.

* * *

Case IV M. T., a twenty-month old female child, while following her mother down the cellar steps, was yanked by one extended arm, screamed with pain, and complained of pain in the wrist. The arm hung limply at the side. She was seen at the office within an hour, the typical signs and symptoms being present. X-ray was negative. The subluxation was reduced with the characteristic click being present and almost immediately the child began to use the arm. It is interesting to note that the same injury occurred one month later when the aunt yanked the child's extended arm resulting in the same signs and symptoms as noted above. The aunt, having been an interested onlooker at the previous reduction and having listened carefully to the description of the pathology and characteristic click with reduction, proceeded to reduce the subluxation. She explained over the phone that the reduction was successful and the click and immediate recovery were diagnostic.

* * *

Case V Baby B, one year of age and just beginning to stand alone, was standing in a telephone booth with his mother. He attempted to drop to the floor and was yanked to an upright position by one arm. He screamed with pain on and off especially when an attempt was made to move the arm. The mother thought the elbow was dislocated. He was seen at home within one hour, signs and symptoms were characteristic and reduction was effected with the characteristic click of reduction occurring. He immediately began to use the injured member and remained recovered.

* * *

Case VI S. K., a two-year-old male child, while playing with a playmate one evening, had one arm pulled while in an extended position, resulting in severe pain and lack of use of the injured member. He was seen at noon the next day and presented the characteristic picture of subluxation of the radial head. X-ray examination was normal. Movements of the elbow were free in all directions except for supination and there was tenderness in the region of the head of the radius. Reduction was attempted several times but revealed no characteristic click and no immediate relief. This case was considered as questionable since without the presence of the click, one cannot be definitely certain of the diagnosis or of reduction. However, some of these cases can be placed in a sling and auto-correction occurs in one or two days. Within three hours the mother called and stated that the youngster had removed the arm from the sling and was using the extremity with almost complete freedom. Thus, I feel that the diagnosis was sustained.

DISCUSSION

Very little has been written concerning subluxation of the head of the radius in the present century. In the American Literature, other than Boyette's article, only Anderson[2] in 1942 and Stone[3] in 1916 have commented on this condition. There have been a few sporadic articles in the foreign literature. Previous to this century, many articles have been written with an attempt to explain the exact mechanism and pathology involved. Although noted as far back as in the writings of Hippocrates, Fournier[4] in 1671 was the first to describe this condition. Duverney[5] in 1751, Gardner[6] in 1837, Poinsot and Hamilton[7] in 1885, Moore[8] and Cushing[9] in 1886, Van Santvoordt[10] in 1887, and Caldwell[11] in 1891, among others, have written on the condition and its probable mechanism. Van Arsdale[12] in 1889, reported one hundred cases and a thorough discussion of the condition with the analysis of the preceding literature on the subject. He places the frequency of this injury at one per cent for purely surgical cases in children under ten years of age. The average age of the children was two and a quarter years, the oldest being nine years and the youngest being only two months. He discusses thirteen theories mentioned in the literature as to the mechanism anatomically. None of these is absolute, but three are considered as deserving of notice, i. e., partial anterior displacement of the head of the radius, interposition of the

orbicular ligament between the radial head and the humerus, and some local injury done to the head of the radius within the capsule of the joint.

Stone in 1916, following a number of experiments in the anatomy laboratory, concluded that with hyperextension and pronation the annular ligament of the elbow joint was allowed to slip over the head of the radius into the space between the head of the radius and the capitulum of the humerus. This appears to be a plausible explanation. Although it is generally felt that X-rays reveal no abnormality, Stone concluded that if X-rays of both elbows are taken there can be measured a greater distance from the head of the radius to the capitulum of the humerus on the affected side, than on the unaffected side.

There is no mention of this condition in pediatric textbooks and only briefly in a few surgical textbooks. Smith,[13] in "Surgical Treatment" by Bancroft and Murray, mentions the condition as do Key and Conwell.[14] They ascribe the pathology to the cartilaginous head of the radius being pulled down through the annular ligament and held there by the contraction of the fibres which have been stretched over it. Dean Lewis[15] in his "Practice of Surgery" merely mentions the condition.

SUMMARY

An injury to the elbow of small children resulting from sudden traction on the extended upper extremity is again brought to the attention of the pediatrician and general practitioner and can be treated by either. Although known since the days of antiquity, this condition has been more or less neglected in present-day publications and teachings and is not widely recognized by members of the profession. This condition occurs in about one per cent of surgical conditions occurring in children under nine years of age, most common in the "toddler age" group. Prompt attention to the characteristic history of injury, the loss of function, the typical position of the extremity, the lack of deformity at the site of injury, and tenderness in the region of the head of the radius will lead to the proper diagnosis. Reduction can be immediately instituted by exerting moderate pressure over the head of the radius with forceful supination of the hand resulting in a characteristic click and usually relief from symptoms.

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Hypocalcemia in Infancy

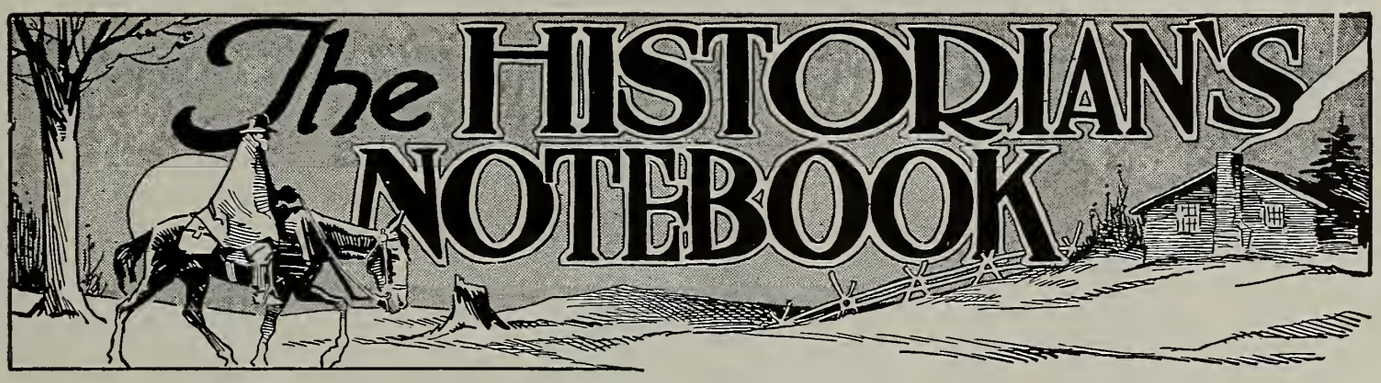
A lowered concentration of serum calcium is generally manifested clinically by signs and symptoms of tetany. With a decreased incidence of rachitic tetany other forms of hypocalcemia have come to the foreground and become the subject of interest to pediatricians. Three such conditions are of particular interest.

1. **Neonatal Tetany.** This condition, occurring during the first two weeks of life, is characterized by a low calcium, a high phosphorus and a normal phosphatase in the serum. It is thought to be caused by immaturity of the parathyroid glands.

2. **Post-acidotic Tetany.** Infants that recover from diarrhea, dehydration and acidosis are prone to develop hypocalcemia, a lowered level of phosphorus and potassium in their serum.

3. **Hypocalcemia in Infantile Hyperventilation.** Infants with respiratory disease apparently developed a reflex stimulation of the respiratory center and hyperventilate excessively. Respirations become deep and pauseless and the children lose large amounts of water from the lungs. Increased concentrations of electrolyte and non-protein nitrogen develop and a hypocalcemia which is thought to be responsible for their convulsions.

The manifestations of tetany cover a wide range of symptomatology. Twitchings, convulsions, vomiting, edema, respiratory disturbances and hemorrhagic manifestations, are the most frequent symptoms. The treatment of hypocalcemia consists in the administration of calcium salts alone or combined with dihydrotachysterol. Calcium chloride is the most efficacious salt, but carries with it the danger of acidosis.—SAMUEL RAPOPORT, M.D., Cincinnati, Ohio. *Abstract of article presented before Section on Pediatrics at Annual Meeting of the Ohio State Medical Association, April 21, 1949, Columbus, Ohio.*



Changes in the Medical Educational Program in Ohio from 1890 to 1910

FREDERICK C. WAITE, Ph. D.

THE twenty years from 1890 to 1910 is a conspicuous period in the history of the advance of American medical education. It is desirable to assemble some of the details of the progress of those years in Ohio medical colleges.

Medical colleges have been in operation in the American colonies and the United States during 184 years. Eleven were active in 1819 when the Medical College of Ohio was founded, the first in Ohio and the second west of the Allegheny Mountains.

NUMBER OF MEDICAL COLLEGES IN OHIO

Thirty-five medical colleges were organized in Ohio in the seventy years from 1819 to 1889, a greater number than in any other state before 1890. More than half of these, eighteen, were sectarian institutions and four of the total number have been designated as fraudulent.

Eighteen institutions had disappeared before 1890 by suspension or by absorption into other medical colleges. This left seventeen in operation on January 1, 1890, two of them fraudulent. Eight new medical colleges were organized in the next ten years, making a total of forty-three in the Nineteenth Century in Ohio. This number does not include the Zanesville Academy of Medicine nor the Toledo Medical School, not the same as the Toledo Medical College. Neither of these two had the power to confer medical degrees. Nor does it include a few postgraduate organizations, each of which soon closed.

Thirteen medical colleges in Ohio disappeared by suspension, absorption, merger or change of name between 1890 and 1900, inclusive, leaving twelve in operation on January 1, 1901, three of them sectarian. One-half of these disappeared in the first decade of the Twentieth Century, leaving six after July 1, 1910. These were, in order of founding of the oldest member: College of Medicine of the University of Cincinnati, Medical Department of Western Reserve University, Eclectic Medical Institute, Starling-Ohio Medical College, Cleveland-Pulte Medical College, and Toledo Medical College. The reduction from seventeen in 1890 to six in 1910, a decrease of more than seventy per cent, is one of the major features in medical educational change in Ohio in these twenty years.

THE REMOTE BACKGROUND

The program of institutional medical education in the United States experienced little progress in the first two-thirds of the Nineteenth Century. The requirement of study of medicine during three calendar years and attendance at two sessions in a chartered medical college before becoming eligible for the degree of Doctor of Medicine remained unchanged. No specific requirement of preliminary education existed in any American medical college and none had a graded course until the Medical Department of Lind University at Chicago inaugurated a required graded course of two sessions in 1859. the first graded medical course in the United States. The medical journals of that time were dubious of the value of the innovation and one of them called it absurd.

The major progressive step before 1859 was increase in the length of the session. This had been twelve weeks until about 1820. It was increased to fourteen weeks in many medical colleges before 1835 and by 1850 the length was sixteen weeks in all of the better institutions and seventeen weeks in a few of them.

The number of medical colleges increased and consequently more men attended at least one

Number	Name of Institution	Year Instruction Began	Year Session Terminated Marking End of Institution	Fate of Institution
1.	**Medical College of Ohio**	1820	1909	Merged with No. 5 to form No. 17
2.	**Medical Dept. of Western Reserve University**	1843	———	Present School of Medicine of Western Reserve University
3.	**Starling Medical College**	1848	1907	Merged with No. 13 to form No. 16
4.	**Cincinnati College of Medicine and Surgery**	1851	1902	Extinct in 1902
5.	**Miami Medical College**	1852	1909	Merged with No. 1 to form No. 17
6.	**Medical Department of Wooster University**	1870	1896	Succeeded by No. 15
7.	**Columbus Medical College**	1875	1892	Absorbed by No. 3
8.	**Toledo Medical College**	1883	1914	Extinct in 1914
9.	**Northwestern Ohio Medical College at Toledo**	1883	1890	Extinct in 1890
10.	**Woman's Medical College of Cincinnati**	1886	1895	Merged with No. 12 to form No. 14
11.	**College of Medicine of National Normal University at Lebanon**	1889	1896	Extinct as a 4-yr. medical college in 1896, but continued as a 2-yr. institution until about 1900
12.	**Presbyterian Hospital and Woman's Medical College at Cincinnati**	1890	1895	Merged with No. 10 to form No. 14
13.	**Ohio Medical University at Columbus**	1892	1907	Merged with No. 3 to form No. 16
14.	**Laura Memorial Woman's Medical College at Cincinnati**	1895	1903	Formed by merger of No. 10 and No. 12, absorbed by No. 5
15.	**Cleveland College of Physicians and Surgeons, Medical Dept. of Ohio Wesleyan University**	1896	1910	Successor of No. 6, absorbed by No. 2
16.	**Starling-Ohio Medical College at Columbus**	1907	1914	Formed by merger of No. 3 and No. 13, became present College of Medicine of Ohio State University in 1914
17.	**Ohio-Miami Medical College at Cincinnati**	1909	1910	Merger of No. 1 and No. 5, became present college of Medicine of the University of Cincinnati in 1910
18.	**Cleveland Homeopathic Hospital Medical College**	1850	1894	Succeeded by No. 21
19.	**Pulte Medical College at Cincinnati**	1872	1910	Merged with No. 22 to form No. 23
20.	**Cleveland Medical College**	1890	1898	Merged with No. 21 to form No. 22
21.	**Cleveland University of Medicine and Surgery**	1894	1898	Successor of No. 18, merged with No. 20 to form No. 22
22.	**Cleveland Homeopathic Medical College**	1898	1910	Formed by merger of No. 20 and No. 21, merged with No. 19 to form No. 23
23.	**Cleveland-Pulte Medical College**	1910	1914	Formed by merger of No. 19 and No. 22, extinct in 1914 (Funds and equipment used to create Ohio State University, College of Homeopathic Medicine)
24.	**Eclectic Medical Institute (College after 1910) at Cincinnati**	1845	1939	Extinct in 1939
25.	**American Eclectic Medical College at Cincinnati**	1879	1896	Extinct in 1896
26.	**International Electropathic Institute at Mentor**	1876	1894	Extinct in 1894, designated as fraudulent
27.	**Medical University of Ohio at Cincinnati**	1883	1891	Extinct in 1891
28.	**Ohio College of Obstetrics, Medicine and Midwifery, at Cincinnati**	1889	1891	Extinct in 1891, designated as fraudulent
29.	**Hygeia Medical College at Cincinnati**	1893	1899	Extinct in 1899

Numbers 1 to 17 were regular medical colleges, numbers 13 to 23 were homeopathic, numbers 24 and 25 were eclectic, and numbers 26 to 29 were nondescript.

Enforcement of Policy of Coeducation	Attendance at 3 Sessions Required for Degree	Inauguration of Required 3-year Graded Course	Inauguration of Required 4-year Graded Course	Increase in the Number of Teaching Weeks in Regular Session						Inauguration of Required Laboratory Courses in Five Subjects				
				Twenty Weeks	Twenty-Two Weeks	Twenty-Four Weeks	Twenty-Eight Weeks	Thirty Weeks	Thirty-Two Weeks	Chemistry	Histology	Pathology	Physiology	Bacteriology
1900	1891	1893	1895	1880	1884	1891	1897	1898	1907	1895	1895	1897	1900	1899
1918	1888	1888	1896	1871		1876		1894	1906	1888	1888	1894	1888	1894
mention	1891	1892	1896	1880		1884	1896	1898	1905	1885	1889	1897	1897	1897
1883	1891	1891	1896	1880		1892	1896			1892	1892	1894	1892	1900
1903	1891	1893	1895	1870	1883	1890	1897		1903	1881	1892	1895	1893	1895
1872	1890	1890		1870		1879				1891	1891	1895	no mention	1895
1881				1875		1880				1883	1890	no mention	no mention	no mention
1883	1889	1892	1895	1883		1888		1900	1904	1885	1892	1896	1892	1896
no nention	no mention	no mention		1883		1885				no mention	no mention	no mention	no mention	no mention
never	1890?	1891				1890?				1892	1892	1892	1892	1894
1889	1891?	1891?				1891?				1891	1891	no mention	no mention	no mention
never	1892?	1892?					1892?			1892?	1892?	1892?	no mention	no mention
1892	1892	1892	1896			1892	1902		1904	1893	1893	1893	1893	1893
never	1895	1895	1896				1898?	1902		1898?	1898?	1898?	1898?	1898?
1896			1896			1896		1897	1909	1896	1896	1896	1896	1896
1907			1907					1907		1907	1907	1907	1907	1907
?			1909					?	?	1909	1909	1909	1909	1909
1871	1889	1891		1875	1878	1883				1891	1891	no mention	no mention	no mention
1879	1890	1891	1895	1872	1878	1888		1900	1906	1889	1895	1895	1899	1895
1890	1890	1890	no mention			1890				1890	1892	1895	1894	no mention
1894	1894	1894	1896				1894			1894	1894	1896	no mention	1896
1898			1898				1898	1904		1899	1898	1898	1899	1898
1910			1910					1910		1910	1910	1910	1910	1910
1877	1890	1890	1896	1879		1895	1899	1903	1907	1890	1890	1895	1913	1905
1883	1892	no mention	no mention	1880						1891	no mention	no mention	no mention	no mention

session in a medical college before beginning the practice of medicine.

One of the purposes in the founding of the American Medical Association in 1847 was announced to be to improve medical education, but this association did little to advance the educational program in its early years. Papers were printed and resolutions adopted, all with recommendations in general terms and lacking specific proposals.

The reform of American medical education began with the graded course at the Medical Department of Lind University in 1859. The American Medical Association in 1865 advised the holding of a convention of medical teachers. Some twenty deans, mostly of medical colleges of the Middle West, met in Cincinnati in 1866 and spent two days in debating the rate of tuition without discussion of the course of study. The next year, in the same city, a group of medical teachers, rather than administrators, met and formed the Medical Teachers Association which proposed a program including four important features, namely, requirement of entrance examinations to determine a minimum of preliminary education for each medical student, increase of length of session from sixteen to twenty-four weeks, requirement of attendance at three sessions of medical lectures before being eligible for a medical degree, and a graded course.

Chicago Medical College had become the successor of the Medical Department of Lind University in 1863 and this program of the Medical Teachers Association was to some extent influenced by the method of teaching at Chicago Medical College which increased its graded course to three sessions beginning in 1868-69.

The program of the teachers association received much publicity and some discussion in Medical journals, but it was too radical for the medical thinking of that day and after a meeting at Washington in 1868 the association suspended activity. However, this association deserves credit for arousing discussion on definite issues and this discussion brought some results in the next few years.

THE IMMEDIATE BACKGROUND

Consideration of the progress from 1890 to 1910 requires an examination of events in Ohio in the twenty years from 1870 to 1890. Therefore, I have read with care more than five hundred issues of catalogues of Ohio medical colleges from 1870 to 1910.

Several Ohio institutions increased the length of session, first to eighteen weeks, and then to twenty weeks prior to 1876. In that year the American Medical College Association was organized. It was considered a revival of the Medical Teachers Association. All regular medical colleges in Ohio joined this association before 1880. The association ruled that all member colleges must enforce a session of at least twenty weeks not later than 1880. All Ohio members responded while one member increased the session to twenty-four weeks beginning in 1876-77.

This association became dormant in 1882 because of resignation of many members arising from disagreement on the granting of honorary degrees. It had recommended an optional graded course of three sessions in 1877. Three member colleges and one sectarian institution in Ohio offered such a course within three years. The association was revived in 1890 under a slightly modified name, the Association of American Medical Colleges, and should be credited with most of the progress in the next fourteen years until the American Medical Association established its Council on Medical Education in 1904, after which date these two organizations and the Federation of State Medical Examining Boards cooperated in the further advance.

The Association of American Medical Colleges in 1894 changed its constitution to require all member colleges to inaugurate a required four-year graded course not later than the session of 1896-97. Some members put this in operation in 1895-96 while others made this four-year course optional for 1895-96 and required for 1896-97.

The recommendation of a three-year graded course by the Medical Teachers Association in 1867 received a slower response. The first action in Ohio was when Miami Medical College in 1870 offered optional "progressive medical teaching" which meant a graded course. Harvard Medical School adopted a required three-year graded course for students entering the session of 1871-72. This action received much attention and was called the "Harvard Plan." Many writers have stated that Harvard Medical School was the first to adopt a required three-year graded course, but before 1871 there were three graded courses in operation: Chicago Medical College, an institution in St. Louis, and a medical college for women in New York City.

Medical colleges in Ohio began in the early eighteen seventies to announce an optional graded course in their catalogues. The language became stronger and students were "offered," "suggested," "recommended," "advised," and finally "urged" to enroll in the optional graded course. The first required three-year graded course in Ohio was begun for students entering the session of 1888-89 at the Medical Department of Western Reserve University.

In the lengthening of the session and in the offering of the optional graded course the regular medical colleges of Ohio were in advance in time

of the sectarian institutions with one exception. Pulte Medical College (homeopathic) of Cincinnati offered an optional graded course in its first session of 1872-73.

SOURCES OF INFORMATION

The announcements and catalogues furnish nearly all the information that follows, supplemented slightly by articles in medical journals, a few historical books, and a few recollections of men who were graduated prior to 1900.

Medical college catalogues of the Nineteenth Century were designed more for advertising to attract students than for recording specific information. They are replete with general statements, encomiums of professors, superlative adjectives, and claims of superiority and priority, often invalid. Those of sectarian institutions at times contain long expository arguments of the virtues of particular theories of therapy. These catalogues are exasperating for one seeking definite facts. Some of them appear to be purposely indefinite in language.

It is often difficult to determine whether statements concerning new features of instruction represent wishful thinking, hopes, proposals to introduce at some indefinite future time, or actual enforcement at the date of the catologue. Also the language often does not show whether a feature is optional or required. Many features of progress were optional for a few or many years before they were required. This is especially true of laboratory instruction in the five subjects which I have selected for tabulation. This article does not pretend to record dates when features were offered as optional. Not until a catalogue makes a definite statement showing that a feature is required of all students and actually in force is the date accepted for entry in the tables that follow. It is possible that some of these features were required before a catalogue makes a definite statement of the fact and that consequently the entered date is unjust to the institution concerned. I disclaim responsibility for any such injustice. It rests on the man or men who wrote or edited the catalogue and failed to make definite statements. Medical college catalogues show progressive improvement after 1890 and soon after 1900 the catalogues of Ohio medical colleges are for the most part really informative as to details.

I have been unable to find complete files of announcements and catalogues for all the medical colleges that existed in Ohio at some time between 1890 and 1910 and am compelled occasionally to enter a date from the earliest availabe catalogue in which a statement occurs that gives specific information. Such an entry is followed by an interrogation mark to indicate that a definite statement may have occurred in an earlier catalogue which I have not seen.

The available catalogues for four institutions are so few that these are not included in any table after Table I. These were not important institutions and two of them have been classed as fraudulent.

PRELIMINARY EDUCATION

The reader may ask why I have not included in the tabulation the important feature of requirements of preliminary education. The reason is that the facts are not stated definitely enough to tabulate. Medical colleges in Ohio began in the middle eighteen seventies to announce an entrance examination for applicants who were not graduates of colleges of arts, academies, or high schools. The early statements give no information of the scope of such examination until 1879 when one of the better institutions listed the subjects in which the applicant would be tested by written examination. The list approximates the knowledge that should have been acquired by completion of two years in an academy or high school. These secondary institutions in Ohio at that time usually had a course of three years. Not all the medical colleges in the state reached such a definite announcement until about 1896.

Moreover, the early examinations were conducted by an officer of the medical college which the applicant was seeking to enter. The desire for quantity of medical students was prominent because their tuition was the only source of income. The quality of those who enrolled was less emphasized. Examinations given by medical college officials were apt to be lenient. Sources other than catalogues show that in some medical colleges in the state the "entrance examination" consisted of an interview of ten minutes with the dean or registrar.

The quality of examinations in the member colleges of the Association of American Medical Colleges improved after the revival of that association in 1890.

No uniform minimum requirement of preliminary education was in force in Ohio until the State Board of Examination and Registration began to require a medical student's certificate of every entrant to a medical college in the state. This requirement became effective in 1903.

An event in Ohio regarding preliminary educational requirements that deserves mention is that the Medical Department of Western Reserve University began for the session of 1901-02 to require that every entrant should have completed the junior year of a college of arts and science. This was the third medical college in the United States and the first west of the

Allegheny Mountains to require any college work for entrance to a medical college.

CRITERIA OF PROGRESS

I have selected fifteen features as criteria of progress. One of these is adoption of a definite policy of coeducation that was not later interrupted after being put in force. Some educators did not consider coeducation as progress and delayed its inauguration for many years. The Cincinnati College of Medicine and Surgery tried to solve this debatable problem by establishing a college for women as a department of the parent institution. After a trial of three years the medical college for women secured a separate charter and moved to a different building although the teachers continued to be largely those of the parent institution and the laboratories of the parent institution continued to be used by the women students.

Other criteria selected are: increase in length of sessions; requirement of attendance at three sessions before becoming eligible for the medical degree, replacing the requirement of two sessions traditional for more than a hundred years; adoption of the graded course of three sessions; adoption of the graded course of four sessions; and beginning of required laboratory courses in bacteriology, chemistry, histology, pathology, and physiology.

The entered date is in each case the year in which the session began when the feature became effective. The year in which that session ended is omitted. Emphasis is necessary that the entered dates are those of enforcement for all students and not of the announcement which preceded enforcement by from one to four years. No entry concerns an optional course.

Preliminary and supplementary sessions given by several institutions are not included. The number of teaching weeks is computed from the announced dates of opening and of commencements, after deducting the length of the Christmas vacation which began to appear in the middle eighteen eighties.

COMMENTS

These tables assemble information not heretofore available in one place. Study of them will show the reader which institutions were leaders in the progress and which were laggards. Discovery of missing catalogues would eliminate the interrogation marks in two of the tables and might change some dates. A survey of the faculty minutes of these medical colleges would probably eliminate many of the entries of "no mention" and supply dates not available in the catalogues.

The number of different institutions is less by three than the number listed in first column because institutions number six and fifteen was one institution under a change of name. This also applies to numbers eighteen, twenty-one, and twenty-two. The largest number of medical colleges in operation in Ohio in any one year after 1888-89 was eighteen in 1889-90, 1890-91, 1893-94, and 1894-95.

The Medical Department of Western Reserve College and University, the Cleveland Homeopathic Hospital Medical College, and the Eclectic Medical Institute were coeducational during short or long periods prior to the dates entered in the Table, but had abandoned the policy which was again adopted at the dates entered.

The long continuance of the twenty-week session shown for two medical colleges was the result of a policy not countenanced in any regular medical college after 1856. The Eclectic Medical Institute gave two sessions and graduated two classes in each year until 1895 and the American Eclectic Medical College did this throughout its existence.

The last table shows three institutions enforcing required laboratory courses in chemistry and histology and three others in chemistry before they enforced the graded course. Such courses must have been brief and little more than demonstrations. The need of laboratory instruction was an important argument in adoption of the three-year graded course and the desire to increase the amount of laboratory instruction was a leading factor in the increase to a four-year graded course. This also influenced the increase in lengths of sessions.

Enforcement of laboratory instruction in five subjects did not entail establishment of five separate laboratories because bacteriology and pathology were taught in one laboratory in the early period and histology was often taught in the same laboratory or in the laboratory of physiology. Thus, three, or at most four, laboratories sufficed for five subjects.

The inauguration of full-time teachers was an important factor in promoting the quality of teaching in medical colleges of Ohio. However, information is not readily available to tabulate the dates when this was begun in each of the institutions. The first full-time professor in the Medical Department of Western Reserve University was in the session of 1893-94 and increased to three professors in the next session. This is considered to be the first instance of this policy in Ohio, although some medical colleges had teachers of chemistry who were full-time teachers but served in two different institutions coincidently.

Industrial Hygiene in Bolivia, Peru, and Chile, by J. J. Bloomfield, U.S. Public Health Bulletin No. 301, is the report of a study undertaken at the requests of the governments concerned. It covers various socioeconomic factors as well as all aspects of industrial life in his report.

Proceedings of The Council . . .

Important Business Transacted at Sessions Held at Granville, Sept. 17-18; Conferences Held With Committee Chairmen; Plans for Coming Year

THE annual fall business session of The Council of the Ohio State Medical Association and a joint conference with standing committee chairmen and A. M. A. delegates were held at the Granville Inn, Granville, Ohio, September 17 and 18, 1949. All members of The Council were present except Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District. Those attending as guests of The Council were: Dr. Carl A. Wilzbach, Cincinnati, Chairman of the Committee on Education; Dr. John A. Caldwell, Cincinnati, Chairman of the Judicial and Professional Relations Committee; Dr. James G. Kramer, Akron, Chairman of the Committee on Public Relations and Economics; Dr. Martin W. Diethelm, Toledo, Chairman of the Committee on Scientific Work; Dr. Jonathan Forman, Columbus, Editor of *The Journal*; Doctors C. C. Sherburne, Columbus, G. A. Woodhouse, Pleasant Hill, Wm. M. Skipp, Youngstown, Ohio Delegates to the American Medical Association; Secretaries Charles S. Nelson and G. H. Saville; Mr. Hart F. Page, Assistant Director of Public Relations; and Mr. R. Gordon Moore, Assistant Managing Editor of *The Journal.*

Following is a report of the business transacted by The Council at three sessions held during the two days:

After introduction of the committee chairmen and delegates, President Lincke called for action on the minutes of the last meeting of The Council held on April 18, 1949. On **motion** duly made, seconded and unanimously **carried,** the minutes of that meeting were **approved.**

MEMBERSHIP AN ALL-TIME HIGH

Membership statistics were reported by the Executive Secretary as follows: Total membership as of September 16, 1949, 7,363, an all-time record; compared to a total membership of 7,331 on December 31, 1948.

Members of The Council then reported on activities in their districts and on visits to their respective county medical societies.

PEDIATRICS SURVEY REPORT

A letter from Dr. James G. Kramer, Akron, Chairman of the Committee on Public Relations and Economics of the Ohio State Medical Association, written on behalf of the Ohio Committee on Pediatrics, was read and discussed. In the letter Dr. Kramer referred to a proposed final chapter of the Child Health Study made by the Pediatrics Committee in Ohio in which certain recommendations and conclusions are enumerated. The question was also discussed by Dr. Benjamin Hoyer, Cincinnati, who served as Chairman of the survey committee. Dr. Kramer and Dr. Hoyer requested The Council to authorize publication of the final chapter, which includes the recommendations and conclusions, in *The Journal.* After going over the recommendations and conclusions, paragraph by paragraph, The Council suggested several minor deletions and then on **motion** duly made, seconded and unanimously **carried, approved** publication of the amended report in an early issue of *The Journal.* (See page 1012, October, 1949, issue of *The Ohio State Medical Journal* for the report.)

The appointment of a special committee by the President to study the recommendations made in the pediatrics report, to formulate a policy on such recommendations, and to report back to The Council at an early meeting, was authorized on **motion** duly made, seconded and unanimously **carried.**

FIFTY-YEAR AWARDS

The Executive Secretary distributed to members of The Council lists of physicians in their district who are eligible for the 50-year emblem and certificate.

On **motion** duly made, seconded and unanimously **carried,** it was agreed that each Councilor would take up this matter immediately with the officers of the county societies in his district and arrange for a suitable meeting at which the 50-year awards could be presented on behalf of the Ohio State Medical Association. It was agreed that any unusual cases would be discussed by each Councilor with the Executive Secretary for the purpose of working out any special arrangements which might be required.

1950 ANNUAL MEETING

Dr. Martin W. Diethelm, Toledo, Chairman of the Committee on Scientific Work, presented a report from his committee, containing the following recommendations with respect to the program and setup for the 1950 Annual Meeting to be held in Cleveland, May 16, 17 and 18, at the Cleveland Public Auditorium and Hotel Cleveland:

"That there be no regular sessions of any of the scientific sections but that the sections

be requested to assist in developing speakers and topics for general sessions.

"That the following schedule for the program be recommended to The Council for consideration:

Tuesday, May 16

10:00 A. M. - 12 M.	House of Delegates Business Session and Luncheon.
1:00 P. M. - 2:30 P. M.	Medical Topics of the Day. (Three running simultaneously.)
2:30 P. M. - 3:00 P. M.	Recess.
3:00 P. M. - 5:30 P. M.	General Session. (Program to be sponsored by the Section on Surgery, Section on Obstetrics and Gynecology, and Section on Anesthesiology.)

Wednesday, May 17

9:00 A. M. - 10:30 A. M.	Instructional Courses. (Five courses running simultaneously.)
10:30 A. M. - 12:00 M.	General Session. (Discussion and speakers on social, economic, and legislative questions.)
1:00 P. M. - 2:30 P. M.	Medical Topics of the Day. (Three running simultaneously.)
2:30 P. M. - 3:00 P. M.	Recess.
3:00 P. M. - 5:30 P. M.	General Session. (Program to be sponsored by the Section on General Practice, Section on Nervous and Mental Diseases, and Section on Medicine.)
7:30 P. M.	Annual Banquet.

Thursday, May 18

9:00 A. M. - 10:30 A. M.	Instructional Courses. (Five courses running simultaneously.)
10:30 A. M. - 12:00 M.	Instructional Courses. (Five courses running simultaneously.)
12:00 M.	House of Delegates Luncheon and Business Session.
1:00 P. M. - 3:30 P. M.	General Session. (Program to be sponsored by the Section on Public Health, Section on Eye, Ear, Nose and Throat, and Section on Pediatrics.)"

The report also contained nominations for vacancies on the program committees of the various scientific sections made by Dr. Diethelm and President Lincke.

The report of the Committee on Scientific Work, as outlined above, was approved on **motion** duly made, seconded and unanimously **carried.**

Attention was called to the death of Dr. John W. Holloway, Cleveland, who had been elected chairman of the Section on Surgery. On **motion** duly made, seconded and unanimously **carried,** The Council named Dr. Donald M. Glover, Cleveland, as chairman of the Section on Surgery to succeed the late Dr. Holloway.

The Executive Secretary reviewed some of the problems and difficulties which arose during the 1949 meeting in Columbus because it was necessary to split the meeting between the Neil House and the Deshler Hotel. Members of The Council agreed that the facilities in Columbus are no longer satisfactory. It was pointed out that plans are being made for the building of a public auditorium in Columbus which would eventually solve the Columbus situation. Contemplating that it might be necessary to hold the 1952 Annual Meeting in Cleveland rather than in Columbus, on **motion** duly made, seconded and unanimously **carried,** the Executive Secretary was instructed to secure tentative dates for 1952 from the Cleveland Convention and Visitors' Bureau and the Cleveland Public Auditorium, the final decision subject to action by The Council at a later date. The 1951 Annual Meeting will be held in Cincinnati on April 24, 25 and 26.

A financial statement regarding the 1949 Annual Meeting was presented by the Executive Secretary. This showed total expenditures of $13,451.84 and that the amount budgeted had been $15,000. Receipts from exhibit space sold and from the sale of banquet tickets totaled $12,131.00.

A.M.A. ASSESSMENT

There was a general discussion of the status of the collection of the special A. M. A. $25.00 assessment in Ohio. The report shows that approximately 61 per cent (4,461 members) of the members of the Association had paid the A. M. A. assessment as of September 1, 1949, and that this placed Ohio in about 34th position among the various state medical societies. Figures showing the A. M. A. assessment collection by counties in comparison to membership were distributed to members of The Council.

Members of The Council expressed themselves as not being satisfied with the response from the membership as a whole. On **motion** duly made, seconded and unanimously **carried,** the Executive Secretary was instructed to present to each Councilor the names of the members in his district who have not paid the A. M. A. assessment

so the Councilor could take up this matter immediately with the officers of the county medical societies involved for the purpose of working out a plan for the collection of the assessment from unpaid members.

PUBLIC RELATIONS REPORT

Mr. Saville, Director of the Department of Public Relations, then presented a very complete report on the public relations activities of the State Association. His report stated that almost one million copies of A. M. A. public education campaign material and other material supplied by the State Association have been distributed to physicians and laymen.

Mr. Saville also pointed out that the Speakers' Bureau is functioning smoothly in providing speakers for state, district and local gatherings and that packages of material are being sent to all of the public and school libraries in Ohio and are being furnished to teachers of public speaking for use by their students in discussions of health and medical programs and proposed legislation pending in Congress.

Also, he pointed out that the State Association is presenting exhibits at a dozen or more county fairs being held this fall and had presented an exhibit at the State Fair held in late August in Columbus. Also, he stated that exhibits are being presented at the conventions of various lay groups, such as the Ohio Congress of Parents and Teachers, the Ohio Welfare Conference, etc.

Mr. Saville also discussed a communication received from a public relations firm offering its services to the State Association on public relations matters. On **motion** duly made, seconded and unanimously **carried**, The Council expressed itself as believing that it would not be feasible to engage an outside organization to handle public relations activities at this time, but that the matter would be given consideration later if outside help was deemed necessary.

The possibility of making greater use of the facilities and services of the full-time offices maintained by some of the larger medical societies in Ohio was discussed. On **motion** duly made, seconded and unanimously **carried**, the Department of Public Relations was authorized, to hold a conference of the full-time executive secretaries of the local societies for the purpose of working out a plan whereby their offices could be tied in closer with the public relations activities of the Association.

HEALTH LEGISLATION

The Executive Secretary presented a report on the actions of the 98th Ohio General Assembly on medical and health legislation and on the status of proposed health and medical legislation pending in Congress.

On **motion** duly made, seconded and unanimously **carried**, the Executive Secretary was instructed to arrange for a conference sometime after the first of the year for county medical society officers and legislative and public relations committeemen for the purpose of discussing activities during the political campaigns of 1950 and the primary and general elections to be held next year.

RURAL HEALTH ACTIVITIES

Dr. Carll S. Mundy, Toledo, Chairman of the Committee on Rural Health, presented a report on recent activities of that committee. The report referred to the presentation of the 1949 Ohio State Medical Association rural medical scholarship to Mr. C. Craig Wright of Winterset. The scholarship was presented to Mr. Wright by President Lincke at a state-wide meeting of 4-H Club members in Columbus on September 14.

Dr. Mundy pointed out that his committee is preparing outlines for lectures on rural general practice to be presented before senior medical students and that as soon as the outlines have been completed a conference will be held with the deans of Ohio's three medical schools. He stated that the committee is giving further study to the proposal for externships with rural general practitioners.

Dr. Mundy made brief reference to the soil analysis and health project under way in Athens County. He submitted to The Council a recommendation of his committee that the Ohio State Medical Association sponsor a dinner meeting for interns and residents in some area of the State at which such subjects as general practice, medical ethics, medical organization, medical economics, etc., would be discussed, to be followed by a general round-table discussion. He said that such a conference would be on an experimental basis and if successful would be imitated in other areas.

On **motion** duly made, seconded and unanimously **carried**, The Council **approved** the report and recommendations of the Committee on Rural Health and congratulated the committee on its constructive work.

SCHOOL HEALTH COMMITTEE REPORT

A report of the Committee on School Health was presented by the Executive Secretary on behalf of that committee. The report revealed that members of the committee are preparing memoranda to be used as a basis for pamphlets on various school health problems and questions and that these pamphlets would be printed and distributed to the school health committees of county medical societies as soon as the committee has completed its work on them. It was pointed out that a meeting of the committee would be held on October 9 to review the data compiled to date. The report also pointed out

that considerable study had been given to proposed legislation before Congress known as the National School Health Services Act of 1949 and what effect its passage would have on school health activities in Ohio.

On **motion** duly made, seconded and unanimously **carried**, the report of the Committee on School Health was **approved.**

WORKMEN'S COMPENSATION

Dr. H. P. Worstell, Columbus, submitted a report on behalf of the Committee on Industrial Health and Workmen's Compensation. He referred to certain increases in the medical and surgical Fee Schedule of the State Industrial Commission, effective July 1, 1949. Dr. Worstell also stated that communications had been received from a number of specialty groups with respect to additional changes in the fee schedule and that these matters would be considered by his committee at its next meeting. He called attention to the fact that his committee is sponsoring the program for the medical section of the Ohio State Safety Conference to be held in Cleveland on September 20, 21 and 22, and that four excellent out-of-state guest speakers had been secured to present that program.

On **motion** duly made, seconded and unanimously **carried**, the report of the Committee on Industrial Health and Workmen's Compensation was **approved.**

POSTGRADUATE EDUCATION

Dr. Carl A. Wilzbach, Cincinnati, Chairman of the Committee on Education, and the Executive Secretary reported informally for that committee. Dr. Wilzbach pointed out that the committee had not made any definite plans for presenting postgraduate lectures this fall as there appeared to be a difference of opinion as to whether it would be necessary and feasible to hold sessions like those in the past which had not been too well attended.

After a full discussion of this question The Council, on **motion** duly made, seconded and unanimously **carried**, expressed itself as believing that postgraduate lectures should not be held this fall but that efforts should be concentrated on providing teams of speakers which could be made available for county society and district meetings.

In the discussion it was pointed out that the Committee on Cancer has a number of teams organized and is offering its services to county medical societies and that perhaps this would be a more practical approach to the question of postgraduate education than the holding of formal meetings at certain designated areas. Attention was called to the fact that there are so many medical meetings it is virtually impossible to secure adequate attendance at some of the area meetings and that it probably would be better to present speaking talent before county society meetings where more physicians in each county would have an opportunity to attend.

WOMAN'S AUXILIARY

A communication from the editor of the *Woman's Auxiliary Bulletin*, asking for an opinion as to whether it would be proper and feasible for the *Bulletin* to solicit and accept advertising, was referred to the Woman's Auxiliary Advisory Committee, on **motion** duly made, seconded and unanimously **carried.**

A suggestion from the Executive Secretary, that the Ohio State Medical Association sponsor a public relations conference in Columbus for the officers, legislative and public relations chairmen of the local auxiliaries, was discussed. On **motion** duly made, seconded and unanimously **carried,** The Council tentatively approved the idea and authorized the Executive Secretary to take up the matter with the proper officials of the Auxiliary for their opinion and advice.

RECENT A.M.A. MEETING

Reports on the June meeting of the American Medical Association House of Delegates at Atlantic City were presented by the Ohio delegates present at this meeting and reference was made to the complete reviews of the A. M. A. session carried in issues of *The Journal.*

A report from the Bureau of Medical Economic Research on its study of life insurance examination fees was presented. No action was taken by The Council.

SPECIAL TRAIN AUTHORIZED

The Council, on **motion** duly made, seconded and unanimously **carried**, authorized the Executive Secretary to make arrangements for an Ohio State Medical Association special train to San Francisco in June, 1950, when the American Medical Association will meet in that city.

A brief report was presented by Dr. Mundy on the status of Ohio Medical Indemnity, Inc., showing a total enrollment of 560,000 persons as of August 31, 1949. He also reported that the enrollment of individuals who are "direct pays" to Blue Cross has been started in the Cincinnati area and that similar programs would be started in other parts of the State if the experience in Cincinnati is good. Also, it was pointed out that Ohio Medical Indemnity is now enrolling persons in Licking County.

AMENDMENTS APPROVED

A communication from the Academy of Medicine of Lima and Allen County, enumerating certain amendments to the Constitution and By-Laws of that Society which have been adopted by the Society, was reviewed. On **motion** duly made, seconded and unanimously **carried**, the

revisions in the Constitution and By-Laws of the Academy of Medicine of Lima and Allen County **were approved**

A similar communication from the Clark County Medical Society was reviewed and on **motion** duly made, seconded and unanimously **carried**, the amendments adopted to the Constitution and By-Laws of that society **were approved.**

APPROVE FEE SCHEDULE

A request from Dr. Lillian Marks, Medical Director, Services for Crippled Children, Ohio Department of Public Welfare, that The Council approve the new fee schedule for special services of that division, which had been drafted by the professional advisory committee of the division, was read and discussed. The fee schedule was reviewed and on **motion** duly made, seconded and unanimously **carried**, was **approved.**

On **motion** duly made, seconded and unanimously **carried**, the Executive Secretary was requested to ask Dr. Sam Rosenfeld, Jr., Columbus, to represent the Ohio State Medical Association at the decennial meeting of the United States Pharmacopoeial Convention to be held at Washington, D. C., May 9 and 10, 1950; and that Dr. Rosenfeld's expenses be paid by the Association if he accepts the invitation.

DIABETES PROGRAM

A communication from Dr. Howard F. Root, Chairman, Committee on Diabetes Detection of the American Diabetes Association, New York City, was read. The communication requested the Ohio State Medical Association to approve the diabetes detection program of the association, which will be presented during the week of October 10-16, 1949. Following a general discussion, The Council reaffirmed the action taken at its meeting on November 14, 1948, reading as follows:

"That the Ohio State Medical Association approves the proposed program of the American Diabetes Association to educate the public and the medical profession on various phases of diabetes and its control but that the Association does not approve at this time a proposal by that Association for establishing so-called detection centers or clinics, it being the sense of The Council that such matters should be handled by the physician in private practice in his own office or in established hospitals."

The Council considered a lengthy report from the Columbus League of Nursing Education, outlining a proposed program for the training of practical nurses as a part of the vocational education section of the Columbus public school system. The Columbus League of Nursing Education had asked The Council to study the proposed program and to advise of its approval or disapproval. On **motion** duly made, seconded and unanimously **carried**, The Council **approved** the program in principle, suggesting that the technical phases should be worked out jointly with representatives of the Columbus League of Nursing Education, State Nurses' Board, the Ohio State Nurses' Association, and school officials.

HEART PROGRAM

A letter from Dr. John N. McCann, Youngstown, regarding plans for the formation of an Ohio State Heart Association, was read and discussed. Although action by The Council was not specifically requested, The Council, on **motion** duly made, seconded and unanimously **carried**, **approved** the formation of the Ohio State Heart Association in principle and reaffirmed its action of April 18, 1949, with respect to the Central Ohio Heart Association, which action approved certain principles and policies agreed to by the Central Ohio Heart Association and pointed out that no program should be placed into effect in any county until it has had the approval of the county medical society.

A contribution of $100.00 from the general funds to the National Society for Medical Research, Chicago, was authorized on **motion** duly made, seconded and unanimously **carried.**

The Committee on Public Relations and Economics was requested to study the possibilities of having proposed legislation drafted for action by the next Ohio General Assembly on the matter of making unwanted or impounded dogs available for scientific research and to report back to The Council prior to the next regular session of the State Legislature.

ACADEMY ASKED TO INVESTIGATE

A letter from Dr. Stuart B. Marks, Secretary of the Cleveland Society of Anesthesiologists, was read and discussed. It referred to certain paragraphs in a rider which has been attached to the contract of the Cleveland Hospital Service Association (Blue Cross). In his letter Dr. Marks stated that in the opinion of many the rider covers professional services and should not be included in the hospital contract. He specifically requested, on behalf of the Cleveland Society of Anesthesiologists, that the matter be investigated and acted upon by the Ohio State Medical Association. On **motion** duly made, seconded and unanimously **carried**, The Council respectfully requested the proper authorities of the Cleveland Academy of Medicine to make an investigation of this question and report its findings and recommendations to The Council.

A letter from the Illinois State Medical Society, asking whether or not the Ohio State Medical Association plans to bill the American Medical Association for expenses incurred in the collection of the $25.00 A. M. A. assessment, was considered. The Council, on **motion** duly made,

seconded and unanimously carried, instructed the Executive Secretary to advise the Illinois State Medical Society that the Ohio State Medical Association did not intend to bill the American Medical Association for such expenses but would absorb such expenses through its public relations budget.

VETERANS ADMINISTRATION

Dr. Heusinkveld read a letter written by Dr. E. J. Geiser, Chief Medical Officer, Cincinnati Regional Office, Veterans Administration, to the Chief Medical Director of the V. A. Central Office, Washington, D. C., on the subect of dual appointments. In the communication Dr. Geiser requested that the regulation prohibiting dual appointments be modified so that the Veterans Administration could secure the services of more and better qualified part-time physicians. No formal action was taken by The Council, but the Executive Secretary was instructed to keep in touch with Dr. Geiser regarding the action taken by the Central Office in Washington on his request and to keep The Council informed on this matter.

The Executive Secretary reported that additional space adjacent to the Headquarters Office, Columbus, would be available October 1 and that the Association could make good use of this additional space. On motion duly made, seconded and unanimously carried, he was instructed to rent such additional space and the Committee on Auditing and Appropriations was authorized to approve the expenditure of funds which might be needed for renovation and improvement of the new space.

A member of The Council stated that some of the physicians in his county are confused regarding the charges for premarital and prenatal blood tests where the individual has secured the test on his own initiative from a laboratory and then presents the blank to the physician for certification. It was the sense of the members of The Council that the physician in such cases would be justified in charging a reasonable fee for signing the blank and making the clinical examination which is required by law in addition to the blood test.

By a unanimous vote The Council authorized the Executive Secretary to make arrangements for the 1950 fall meeting of The Council at the Granville Inn.

There being no further business The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

The Council on Industrial Health of the A. M. A. will hold its Tenth Annual Congress on Industrial Health at the Roosevelt Hotel in New York City, February 20-21, 1950.

Brookings Institution To Study Medical and Hospital Care

The Brookings Institution without fanfare has launched a gigantic fact-finding project which promises to be the most comprehensive survey ever conducted in this country on medical and hospital care.

The project is the first attempt to encompass all sources and all distributors of medical and hospital care—governmental, voluntary, commercial, organized labor, philanthropic, industrial, etc.

It is estimated that the study will require two years' effort on the part of eight full-time staff people, plus participation of specialists in various fields who will be called in as consultants.

It will entail cooperation on the part of national professional societies, labor organizations, insurance companies, governmental agencies, industrial health programs, farm groups and other bodies concerned with one phase or another of this subject.

"If we are to have a sound national health program, the first requirement is to ascertain the facts as to the state of medical service in the United States today," the prospectus of the Brookings study states. "For a comprehensive picture of the availability of medical care in the United States, both private and public organizations should be covered. These would include medical services provided by industry, trade unions, medical societies, philanthropic and fraternal organizations, national health associations, group health and other voluntary prepayment plans, state and Federal medical aid programs including veterans and armed forces, and industrial and commercial insurance."

Cooperation of the U. S. Chamber of Commerce, National Association of Manufacturers, Veterans Administration, the military establishment, state health departments and welfare agencies, Federal Security Agency, American Red Cross, National Health Council and innumerable private and public organizations has been, or will be, solicited.

"The essential factor in order to accomplish the objectives of this survey," the prospectus states, "is to have a competent directing agency to organize the study, enlist the cooperation of those who are in a position to furnish data and to analyze and interpret the facts as a whole."

The Brookings Institution is the non-partisan organization which conducted a survey on the need of compulsory insurance, and in 1948 published "The Issue of Compulsory Health Insurance," which recommended strongly against adoption of a nationalized system.

Workmen's Compensation . . .

New Schedule For Payment of Doctors and Hospitals Set Up To Expedite Work Load; Changes in Law Enacted by 98th General Assembly Reviewed

A NEW schedule for the paying of physicians and hospitals has been set up by the State Industrial Commission in order to bring about a more even distribution of the work load in preparing and mailing out warrants. Previously payments had been made at the end of each month.

Under the new schedule warrants will be mailed out as follows: Physicians from A to F, 20th of the month; physicians from G to L, 25th of the month; physicians, M to R, 30th of the month; physicians S to Z, 5th of the month; hospitals, 15th of the month.

Legislation amending the Ohio Workmen's Compensation Law, enacted by the 98th Ohio General Assembly, became effective September 1. Following is a brief analysis of changes in the law:

Increase in maximum weekly compensation from $25 to $30;

Increase in maximum compensation for temporary total disability from $4,200 to $6,000;

Increase in maximum compensation for permanent partial disability from $6,000 to $7,500;

Ten additional weeks of compensation allowed for loss of arm, leg, hand or foot;

Compensation allowed as follows for loss of hearing: 25 weeks one ear; 125 weeks both ears. No allowance for part loss of hearing;

Allowance for repair or replacement of dentures damaged while in mouth as a result of compensable accident;

Allowance of limited wage loss to employee who has contracted silicosis and has to change occupations at a loss in wages; allowance not to exceed $20 per week for period of 30 weeks;

Increase in maximum death benefit from $7,500 to $8,000;

Only majority vote of Commission needed to approve medical bills over $200 instead of unanimous vote;

Increase in funeral allowance from $250 to $300;

When an award has been made for permanent partial disability and the employee dies from other causes, unpaid installments are to be paid to widow or dependent children;

Rehabilitation expense money increased from $15 to $20 for 52 weeks;

Relieves employer of keeping record of injuries resulting in less than seven days total disability but does not affect right of injured employee to have medical bills paid by Commission, in which event a regular claim blank must be filed.

Provides for payment of awards to persons who have been disabled while in active military service and who have a subsequent industrial injury; part of award due to the industrial injury to be paid from the state insurance fund itself and that part due to war disability to be paid from the fund's "surplus."

Northwestern Association Annual Meeting Held in Toledo

At the 105th meeting of the Northwestern Ohio Medical Association, held in Toledo on October 4, Dr. Ralph E. Rasor, Findlay, was elected president to succeed Dr. Wendell Green, Toledo.

Other officers elected are: Dr. Floyd Yeager, Marion, vice-president, to succeed Dr. Rasor; Dr. C. H. Evans, Findlay, secretary, to succeed Dr. Yeager; and Dr. Richard Hotz, Toledo, treasurer, to succeed Dr. Evans.

The next meeting was scheduled to be held in Lima next fall.

The scientific program included the following speakers and subjects:

Dr. William M. Tuttle, Wayne University College of Medicine, Detroit, Mich., "The Surgical Management of Chronic Pulmonary Suppuration";

Dr. John S. Lundy, Mayo Clinic, Rochester, Minn., "The Present Status of Balanced Anesthesia and Supportive Therapy";

Dr. Paul K. French, University of Vermont, Burlington, Vt., "Practical Evaluation of Antibiotic Therapy";

Dr. Gerald H. Pratt, New York Postgraduate School, "The Diagnosis and Management of Peripheral-Vascular Disease."

At the noon luncheon, after brief talks by Dr. J. Craig Bowman, Upper Sandusky, Councilor of the Third District of the Ohio State Medical Association, and Mr. Charles S. Nelson, Columbus, Executive Secretary of the Association, Dr. Wilbur W. White, president of the University of Toledo, spoke on the subject, "Current Problems of Higher Education."

A two-day sectional meeting of the American College of Surgeons is to be held at the Brown Hotel, Louisville, Ky., February 20-21, 1950. Members of the Ohio State Medical Association are invited.

Solons Inspect British Medical Plan . . .

What Members of Committee on Interstate and Foreign Commerce Think of Programs In England and Sweden Is Reported by Gerald Gross

DURING the past month members of the House Committee on Interstate and Foreign Commerce, which considers most of the proposed medical and health legislation before the Congress, have been visiting England and Sweden, individually or in groups, for the purpose of inspecting the government medical services in those countries. Congressman Robert Crosser, Ohio, chairman of the committee, was among them. He is still abroad. Most of the others who took the jaunt have returned.

What these legislators observed and what they think of the medical situation abroad may have a significant bearing on what Congress does in 1950 on medical legislation. For that reason comments and observations from them fall into the category of spot and important news.

A first-class job of interviewing 11 of the solons has been done by Gerald G. Gross, editor of *Washington Report on the Medical Sciences.* Following are direct quotes from Gross's "Report" of October 3:

"In separate interviews with members of House Interstate and Foreign Commerce Committee who returned last week from their inspection of government medical services in the British Isles and Sweden, your correspondent got the impression that the Congressmen were disquieted by what they saw and heard.

"Conscientiously disquieted, in a manner tending to influence the thinking of those whose previous convictions were on the side of compulsory health insurance as well as those who have been its articulate opponents. The former acknowledged flaws in Britain's nationalized medicine system which they would hate to see introduced over here; the latter confessed they could not help being impressed by the program's popularity and the minimal criticism expressed by doctors whom they had expected to be bitter and antagonistic.

"Notwithstanding President Truman's repeated declarations that he wants Congress to enact as much of his 'Fair Deal' legislation as possible before adjournment, even the most enthusiastic supporters of national health insurance have long since abandoned hope for this year.

"But looking ahead to 1950, the significance of the recent trip made by this Congressional committee—responsible for handling not only the national health insurance bills but all medical and hospital legislation affecting the general population—cannot be overestimated.

"The sojourn made no converts. It did, however, sharpen powers of discrimination. Stock arguments, name-calling and glib but undocumented charges, from whichever quarter they may reach the ears of Interstate members henceforth, will not be received so tolerantly as they have been in the past. Here is what the Congressmen had to say—

"BECKWORTH (D., TEXAS)—You can't nationalize medicine and stop there. It leads to nationalization of other things. The visit was highly beneficial but I returned with my confidence unshaken in the American medical profession and the way we do things in this country.

"DOLLIVER (R., IOWA)—I am more than ever opposed to socialized medicine. I am thoroughly convinced that the British scheme is unworkable over here and it would lower professional and medical care standards. Aneurin Bevan (Minister of Health) is frankly out to extend socialism but, from a personal standpoint, he is a fellow one can't help liking.

"UNDERWOOD (D., KENTUCKY)—The trip will serve to make me more conservative in making up my mind on action that should be taken. I never was for socialized medicine. But I still feel it is necessary for good health services to be made available to all of the people at reasonable rates of payment. I hope the medical profession will help achieve that goal.

"ELLSWORTH (R., OREGON)—What England and Sweden and other countries abroad are doing about their health care systems has no real application to the United States. Their present circumstances and historical backgrounds are both so different from ours that it would be completely futile to make a translation into terms of desirable action over here. Nevertheless, we learned a great deal that will stand us in good stead when health legislation is under consideration.

"WILSON (D., OKLAHOMA)—The insight which I received into the administrative workings of the British and Swedish plans will be very valuable. But I still have reached no conclusions, except that Aneurin Bevan is a most energetic personality. The committee collected

a great amount of information which will prove useful in discussions of pending legislation.

"(Note: Now being drafted is a resumé of the 16-day trip which is to be incorporated in the printed transcript of public hearings on the Thomas-Murray-Dingell omnibus bill conducted earlier this year by the committee.)

"BIEMILLER (D., WISCONSIN)—Every doctor I talked to agreed they could practice better medicine than before; they could prescribe the medicines people really needed and know their patients could get them. Administrative costs are only 2.3 per cent under the present British plan, compared with 8 per cent for the best of our voluntary plans. Bevan went out of his way to point out the distinction between socialized medicine and health insurance. Dr. Charles Hill, secretary of the British Medical Association, was extremely critical of the A. M. A. who, he claimed, had grossly misrepresented their health insurance proposal by saying that the quality of medical care had deteriorated. Dr. Hill also emphatically stated his belief that voluntary health insurance plans could never meet health needs in Great Britain because they could not extend coverage to enough of the population. If you don't have a compulsory health insurance plan with adequate coverage, you walk right into socialized medicine. One bad feature of the British system is that it tries to cover the entire population and every aspect of medical and health care at the same time and there is lack of effective local control at many stages. The Swedish health program is much more applicable to the United States than the British. Sweden's present system of voluntary health insurance, subsidized by the government, will be succeeded in 1951 by compulsory health insurance because voluntary plans just didn't work, even with large government subsidies. In the new scheme, each patient will pay one-fourth of all expenditures for medical care.

"O'HARA (R., MINNESOTA)—From what I saw, I would say that our indigent obtain far better medical care than do those of England and Sweden. The original ideas I had on this subject of providing health services were strengthened by the trip. The British, having jumped into something as big as this without possessing enough doctors and nurses, are having a hell of a time. The Swedish have been more cautious in their approach. As for bills now awaiting action by our committee, I will support those that will relieve the shortage of doctors and nurses but I am still opposed to the school health services bill in its present form.

"LINEHAN (D., ILLINOIS) — Nationalized medicine isn't working over there and it won't work here. People seem to be afraid of Bevan. He's going to be the next prime minister if the Labor party stays in power.

"BENNETT (R., MICHIGAN)—Some of the things I saw confirmed my previous thinking. Others had a contrary effect. British doctors seemed to be more reconciled to the system than I thought would be the case, though this may be due to fear of the consequences if they rebel. One point agreed upon by doctors whom I believe are impartial is that the country attempted too big a gulp at one time. To this Bevan says 'no,' but nevertheless it seems that the program has been swept away from its original objective of furnishing care for the medically indigent and the country has wound up with a complete system of state medicine. It is a purely socialistic scheme, based on the theory that the government can spend your money best.

"McGUIRE (D., CONNECTICUT)—I saw nothing over there I would adopt over here. Bevan, he's the next prime minister, thinks the government can save money by manufacturing hearing aids so private manufacturers are going to be driven out of business. As far as the doctors are concerned, though, they are doing better financially than they were before. I was amazed to learn that.

"GILLETTE (R., PENNSYLVANIA)—I am more opposed to socialized medicine now than I ever was before. It will bankrupt any country.

"(Note: Other members of the committee who were in the European party were Chairman Crosser, Reps. Hugh D. Scott, Jr., (R., Pa.) and Arthur G. Klein (D., N. Y.) who have not yet returned to the Capital, and John B. Sullivan (D., Mo.) and Leonard W. Hall (R., N. Y.) who could not be reached for comment.)"

Public Health Commissions

A competitive examination for appointment of medical officers in the Regular Corps of the United States Public Health Service will be held January 9-11, 1950. Examinations will be held at a number of points throughout the United States, located centrally as possible in relation to homes of candidates. Applications must be received no later than December 12.

Application forms and additional information may be obtained by writing the Surgeon General, U. S. Public Health Service, Federal Security Agency, Washington 25, D. C.

The Regional Fracture Committee of the American College of Surgeons of Western Pennsylvania will meet at the University Club, Pittsburgh, Pa., November 16, at 2 p. m. All members of the profession are invited.

Scrutiny of Tax Returns . . .

National Enforcement Shifts to Mass-Production Techniques As More Agents Go To Work Scanning Returns, According to Business Analyst

THE taxpayer, looking for possible ways to save a dollar, needs more than ever to watch his step. Sleuthing for lost revenue is to be stepped up sharply in months ahead.

Search for tax evasion is to be intensified by 4,250 new revenue agents authorized by Congress. When these are trained and put to work, the Bureau of Internal Revenue will have around 27,000 agents—about as many as it ever has had before at one time.

Revenue agents, too, will be able in the future to cover many more individual cases. The reason is that, when Congress permitted husband and wife to split income for tax purposes, revenue agents were relieved of a major policing job. That was the task of trying to prevent evasion arising from income juggling within families.

EFFECT OF CHANGES

Effect of changes now occurring in the tax-enforcement system are to be felt by many taxpayers. Some people, innocent of any intent to evade tax laws, may find themselves with back taxes to pay. People who have been failing to file returns will feel the weight of a stepped-up tax drive, too. The outlook for particular individuals:

If you make $7,000 a year or more, adjusted gross income, you may not notice any change as a result of the new flurry of activity. The chances are that your past tax returns already have been checked to some degree. In fact, the chances are good that your tax return is being audited carefully.

Last year, the Bureau audited about 2,360,000 returns. Auditing was concentrated on returns showing the highest incomes, because that is where tax liabilities are greatest and yields from extra investigations are high. Approximately 2,000,000 returns, covering incomes of $7,000 and up, accounted for nearly 50 per cent of all income taxes. People in this income group are being checked to a rather fine point under existing procedures.

$5,000 TO $7,000

Between $5,000 and $7,000 a year, however, returns will be checked much more often than in the past. About 2,000,000 returns fall within this range of income. The practice has been to spotcheck these returns, picking up a relative few for thorough examination.

Under new plans, with more men and machines in collectors' offices, it is probable that a high percentage of returns in the $5,000-to-$7,000 class will be audited.

The bureau figures that its added staff will enable it to audit about 500,000 more individual returns every year. The additional audits will tend to be concentrated on returns showing incomes from $5,000 to $7,000.

UNDER $5,000

On incomes under $5,000 a year the biggest changes in tax collecting can be expected eventually, but probably not until 1952 or later. In this class are the big number of taxpayers—about 3,000,000 in the $4,000-to-$5,000 bracket; 7,000,000 in the $3,000-to-$4,000 group; 13,500,000 with incomes between $2,000 and $3,000; 8,000,000 from $1,500 to $2,000. Around 18,000,000 persons make returns on incomes below $1,500 a year, though many of them pay no tax.

Returns covering these lower incomes have been accepted almost entirely on faith in most districts, as a rule. There have been exceptions. Special tax drives have been aimed at improving tax compliance by people, especially self-employed, whose incomes are under $5,000 a year. But the normal check has included only a tiny fraction, under 3 per cent on the average, for auditing. Often the audit was not very thorough.

SAMPLING PLAN

A sampling plan is to provide a big change in checking low-income returns. Officials are selecting by scientific sampling methods nearly 100,000 returns from those showing adjusted gross incomes below $5,000.

These returns will get the same intensive audit applied to the highest income return. That means personal visits or letters from tax agents

The accompanying article is from the August 5 issue of *U. S. News & World Report*, and crystalizes observations of many other writers on the subject. An article by Stanley Mauck in the October issue emphasized the observation that revenue agents have reversed their opinions on many items formerly considered deductible. *The Journal* will publish in the December issue its annual roundup on hints to physicians on making out income tax returns.

to the taxpayers, and verifying of all statements as to dependents, expenses and income. People in all grades of income and in all walks of life, including those who file returns but pay no tax, will be asked to produce records and otherwise prove their statements.

This investigation is the first of its kind on such a large scale. It is designed to show the real size of tax evasion in low income groups. Officials have guessed that the Government is losing from $1,000,000,000 to $3,000,000,000 a year in taxes due but not collected. With 12,500 agents in 1940, the Government collected $393,-909,686 in extra revenue. With 27,000 agents in 1950, the additional collections will be in excess of $2,000,000,000.

The sampling job also is to be a trial run for various kinds of new detection techniques and administrative procedures. What the Bureau really is after is a quick, sure, cheap method for processing millions of tax returns—to ferret out "mistakes." Computing machines will play a big role in any system eventually adopted.

TAX EVASION

Tax evasion thus is to become more difficult at any income level. Tax officials feel that compliance with their rules has been deteriorating dangerously. They say an enforcement campaign is long overdue.

One evidence of resistance to tax laws is that people delay their tax payments even when they do not question the amounts. On Dec. 31, 1948, there were 1,008,558 cases outstanding involving unpaid Federal taxes in which legal actions had been started. The number was nearly 54 per cent larger than a year earlier. This accounts for the increase in tax liens.

Evasion appears to be tried most often by individuals and businesses with a large volume of cash transactions, such as doctors, other professional people, merchandisers, farmers. But the Bureau is going after such delinquents with some new techniques. Special interest is expressed in returns for 1946 and 1947, years of very high income for many self-employed persons. Returns for the taxable year 1945 are "safe" now in general, except in cases of deliberate fraud, because of the statute of limitations.

In the tax drive that will gradually get under way, certain problems will get special attention. In many cases, these problems are completely new, as result of changes in the taxing system and the volume of tax collections.

REFUND CLAIMS

Refund claims are an example. Claims may be paid less easily in the future. In 1948, about 6,000,000 persons claimed larger credits or refunds than they had coming. Each of 4,000,000 claims was for more than $50 extra, according to the records. Most of the refunds had been allowed automatically, before the Government discovered the errors. Collectors are trying to get the money back.

Refunds flow out to taxpayers at a rate of more than $2,000,000,000 a year. This opens up a vast number of new opportunities for troubles between collectors and taxpayers.

TAX TABLES

Tax tables are the source of many errors. Officials believe many taxpayers, in the group with incomes below $5,000 a year, are taking advantage of a practically risk-free way of lowering their tax bills. They simply choose the tax they pay from the wrong column in the tax table that is provided. It is the kind of error that anyone could make, so intent to defraud is virtually impossible to prove.

The average advantage for the taxpayer from that kind of slip is about $100. The extent of this particular mistake is one of the things to be discovered from the new sampling plan.

WITHHOLDING TAXES

Collection of withholding taxes from employers offers an enforcement problem, and the system now being followed may be changed to some extent, as the result of experience. Employers are supposed to make monthly deposits with local banks of taxes collected on wages of employes. About one out of three complies with the requirement.

Losses from cases where withheld taxes never reached the Government are on a relatively small scale so far. But the Bureau wants to tighten enforcement of the deposit rule to remove possibility of larger losses. Another reason is that the deposit system, whereby an employer can end his responsibility by sending a deposit receipt to the tax collector, is to be extended to other taxes, including those for social security.

THE GOAL

The goal of tax collectors is to verify every return they get, at least as to mathematics. Out of 53,000,000 returns, the Bureau's own offices do the figuring for 19,000,000 on Form 1040-A. Of the remaining 34,000,000 returns, only 1 out of 4 is checked for arithmetic.

Even with the new 20 per cent increase in staff, the Bureau will fall far short of its goal. But the campaign is started to get tax enforcement on a mass-production basis. As it is now, tax enforcement varies widely, and often depends on the attitude of a particular tax collector.

Copies of a guide for making surveys of nursing entitled "Measuring Nursing Resources" are available from the Public Health Service, Federal Security Agency, Washington 25, D. C., Att: Division of Medical and Hospital Resources.

A.M.A. Raps Probe . . .

Officials Issue Statement Protesting Use of Anti-Trust Division To Terrorize Physicians and Curb Opposition to Compulsory Health Plan

THE Board of Trustees of the American Medical Association early in October issued a public statement "protesting the use of a police arm of the Government—namely, the Anti-Trust Division of the Department of Justice—in a campaign to discredit American medicine and terrorize physicians into abandoning their opposition to Compulsory Health Insurance."

The statement revealed that up to that time, 16 State and County Medical Societies, and other medical organizations, including the A.M.A. itself, had been made the targets for investigation by the Anti-Trust Division of the Justice Department during the preceding 30 days. Groups under investigation when the statement was issued included:

American Medical Association, New York State Medical Society, Utah State Medical Association, Washington State Medical Society, Arkansas Medical Society, Oklahoma State Medical Association, Michigan Medical Service, Arkansas Blue Cross-Blue Shield Plan, Los Angeles County Medical Society, California; Beckham County Medical Society, Oklahoma; Wayne County Medical Society, Michigan; Harris County Medical Society, Texas; King County Medical Society, Washington; and the New York County, Nassau County and Queens County Medical Societies in New York State.

Shortly after the A.M.A. statement was released, agents of the Department of Justice called at the offices of the Columbus Academy of Medicine, the Cleveland Academy of Medicine, and the Summit County Medical Society, requesting permission to check the correspondence files of those societies and to review the minutes of official meetings of the societies.

A.M.A. STATEMENT

The A.M.A. statement follows:

"This is an official statement of the Board of Trustees of the American Medical Association, protesting the use of a police arm of the Government—namely, the Anti-Trust Division of the Department of Justice—in a campaign to discredit American medicine and terrorize physicians into abandoning their opposition to Compulsory Health Insurance.

"The A.M.A. has opened its records to the Justice Department, without reservation, and medical societies throughout the country undoubtedly will do likewise, but we intend to keep the public fully informed of developments, as we are convinced that these are not *bona fide* anti-trust investigations, and that the American people will not tolerate Police State methods in this country.

POLITICAL IMPLICATIONS

"We would be naive, indeed, if we ignored the political implications of this sudden rush of investigations, attacking medical societies, at a time when the Administration is doing its utmost to stifle opposition to its proposed system of Government-controlled medical care.

"This scheme, it is specifically provided, would be a Government-monopoly, to which every citizen would be compelled to contribute, and which would destroy all the hundreds of Voluntary Health Insurance systems which now provide prepaid health care for more than 61,000,000 of the American people.

"Certainly it will be a travesty on justice if the Anti-Trust Division of the Justice Department can be used to silence opposition to the creation of a Government-trust in medicine.

NO COINCIDENCE

"The American people, we believe, will hardly think it a coincidence that these anti-trust investigations should be ordered at this time—after there have been repeated threats that medical groups would be 'investigated' because of their opposition to socialized medicine.

"The chronology of events, since the American Medical Association decided to make a Nationwide campaign against Compulsory Health Insurance, and in behalf of Voluntary Health Insurance, is, we believe, of real significance.

"In November, 1948, the A.M.A., at its midwinter meeting, voted to collect funds from its members to finance a campaign of public education on this issue. A public announcement was made to that effect.

"Only a month later, in December, agents of the Department of Justice called on the Chicago Medical Society, seeking to check the Society's records in connection with an alleged anti-trust investigation.

BREAK INTO RECORD ROOM

"During the February session of the Board of Trustees of A.M.A. in the early hours of February 10, the Board Room was broken into and records of the Board were thoroughly searched by persons unknown. Brief cases of the Trustees, left in the room, also were searched. Entrance was gained through a window. The facts indicate this was a search for information, rather

than an ordinary burglary. Certainly no friends of medicine would take this means of obtaining medical data.

"A few weeks later, toward the end of February, Administration leaders began threatening medical societies and medical men with 'investigation' as part of their campaign to discredit and intimidate the medical profession. Since then, there hasn't even been much attempt to disclaim the political nature of these investigations.

CAMPAIGN BY INVESTIGATION

"On February 28, 1949, for example, one of the national press associations carried a dispatch from Washington quoting Government officials as stating that anti-trust actions would be started against 'several' medical societies soon after the Compulsory Health Insurance drive was started in Congress.

"The implication was plain that the 'investigation' would be part of the Administration's campaign for its socialized medicine scheme.

"The threats made then are now realities. An epidemic of 'investigations,' aimed at medical societies and voluntary medical care plans, has broken out in widely separated states and cities all over the country.

ABUSE OF PUBLIC POWER

"We want it clearly understood that we believe this attack on the medical profession stems from the Anti-Trust Division of the Justice Department and political string-pullers who have exerted influence on that agency. We believe it to be an outrageous abuse of public power which far transcends in gravity the issue of Compulsory Health Insurance, vital as that issue is.

"We recognize that politically motivated attacks have been made on many other groups by this division of the Government—and we invite their cooperation with American medicine in an effort to alert the American people to the seriousness of this trend toward Police State methods. If the police arm of the Government is used to intimidate doctors and others, and this abuse of power goes unchallenged, it may next be used to terrorize publishers or grocers, farmers or lawyers, Catholics, or Jews, or any other minority in the Nation."

Anesthesiologists Elect Officers

Dr. George F. Collins, Columbus, was elected president of the Ohio Society of Anesthesiologists at the meeting held in the Mayflower Hotel, Akron, September 23 and 24. He succeeds Dr. Kenneth C. McCarthy of Toledo.

Dr. Lloyd E. Larrick, Cincinnati, was elected vice-president and Dr. Brant B. Sankey, Cleveland, was elected secretary-treasurer. Approximately 150 doctors attended the two-day meeting.

Hotel Reservations for 1950 A. M. A. Session at San Francisco

Ohio physicians who may be planning to attend the 1950 session of the American Medical Association at San Francisco, June 26-30, should write for hotel reservations to Mr. Walter Swanson, general manager, San Francisco Convention Bureau, 200 Civic Auditorium, San Francisco.

The Palace has been designated the headquarters hotel and will house the members of the House of Delegates and other officials of the A. M. A.

Medical Society Officers To Meet At Washington Session

The Sixth National Conference of County Medical Society Officers will be held in Washington, D. C., during the Clinical Session of the A. M. A. The meeting is scheduled for December 8 at 8 p. m. in the Hotel Statler. All doctors and their wives are invited to attend.

The theme of the meeting will be "Community Health Leadership," and will be divided into three phases as follows:

Outstanding Local Achievements—"The Miracle of Flint," by Dr. A. L. Tuuri, medical director, Mott Children's Center, Flint, Mich.; and "Erie County Rings the Bell," by Dr. Roy L. Scott, president, Medical Society, County of Erie, Buffalo, N. Y.

National Programs Depend on Local Achievements—"The American Legion's Community Development Program," by George N. Craig, national commander, the American Legion, Brazil, Ind.; and "The Program of the United Mine Workers," by Dr. Warren F. Draper, executive medical officer, Welfare and Retirement Fund, U. M. W. of America, Washington, D. C.

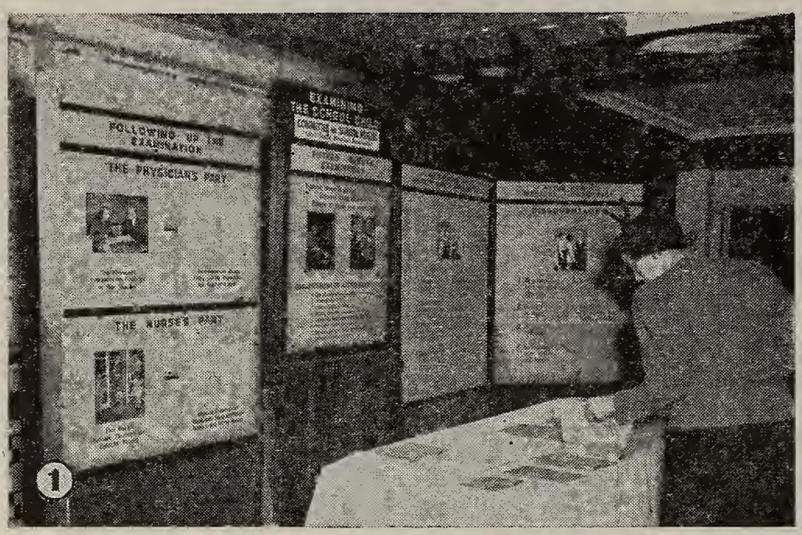
The Doctor's Prognosis—by Dr. Joseph Wall, past-president, Medical Society, District of Columbia.

Grants in Mental Field

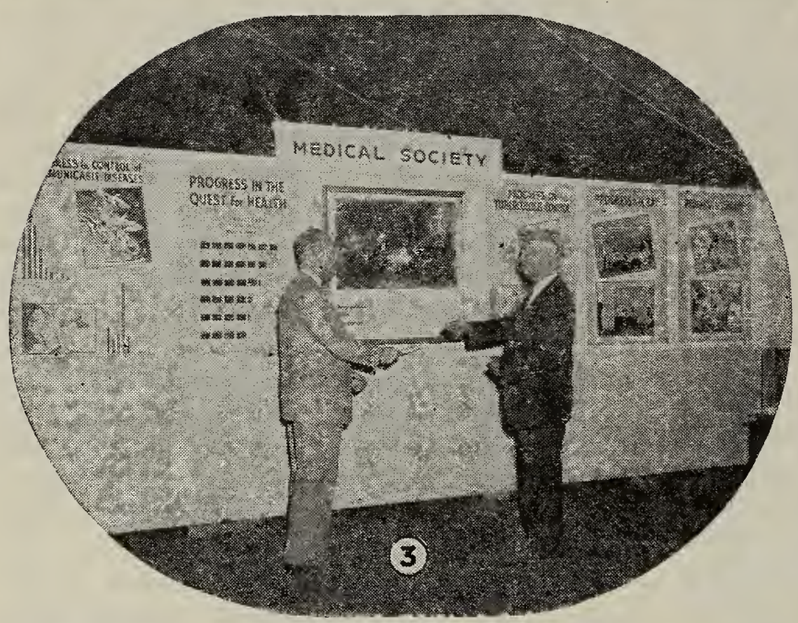
Twelve new Public Health Service grants for research on causes and methods of preventing and treating mental and emotional disorders were announced by the Federal Security Administrator.

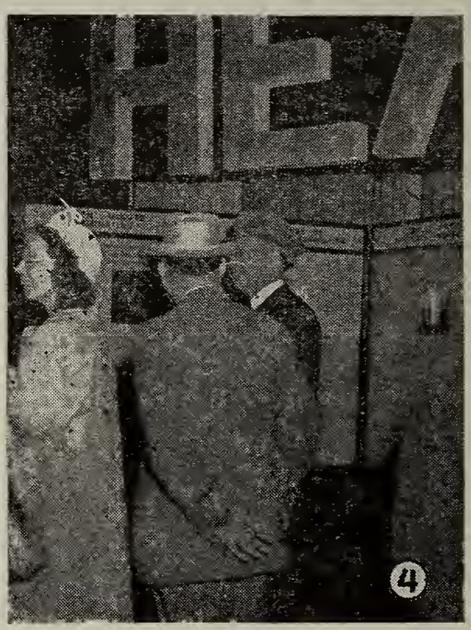
The grants total $139,023 and are in addition to 54 research projects totalling $974,944 which have received support since 1947 when Federal aid for mental health research first became available. The grants were made by the National Institute of Mental Health of the National Institutes of Health, research branch of the Public Health Service.

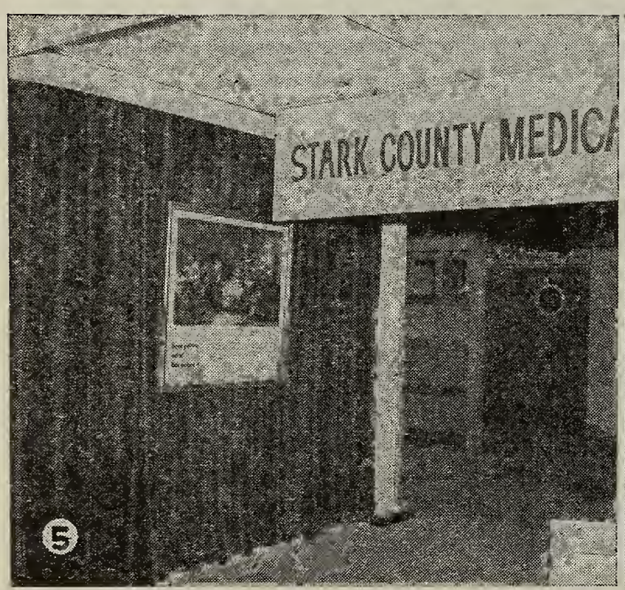
Some of Exhibits Sponsored by Association This Fall













1. One of approximately 2,200 persons, who attended Ohio P-T. A. Congress, examines literature.

2. Mrs. A. R. Grierson and Mrs. H. W. Lehrer of the Woman's Auxiliary to the Erie County Medical Society help arrange booth at Sandusky Fall Festival.

3. Dr. W. R. Schultz, president of the Wayne County Medical Society, hands a folder to a visitor at Wooster.

4. Group examines exhibit at Ohio State Fair, Columbus, under the huge word "Health."

5. Section of the exhibit at the Stark County Fair in Canton.

6. Dr. A. D. Robertson, president of the Ashland County Medical Society, discusses literature with Trent Dill and John D. King of the Akron Blue Cross Plan at the Ashland County Fair.

(Story on facing page.)

(O. S. M. A. Staff Photos.)

Exhibits Tell the Story . . .

Association in Cooperation with County Society and Other Groups Tells Medical Profession's Point of View to Thousands of Citizens

THE Ohio State Medical Association, through its Public Relations Department, has sponsored or cosponsored many exhibits this fall, and through this means has presented the medical profession's point of view on health and welfare matters to thousands of citizens.

Cooperating with the Association in these efforts is the Bureau on Scientific Exhibits of the A. M. A. which lent much of the exhibit material. Appropriate educational literature and pamphlets were distributed at each of the exhibits.

Exhibits included the following:

1. An exhibit featuring school health at the Ohio Parent-Teachers Association Congress in Columbus, October 4-6.

2. An exhibit featuring the campaign against compulsory sickness insurance at the Sandusky Fall Festival, September 28-30, cosponsored by the Woman's Auxiliary to the Erie County Medical Society.

3. An exhibit showing progress in medicine and urging that politics be kept out of medicine, at Wooster, September 13-17, cosponsored by the Wayne County Medical Society.

4. An exhibit on school health at the Ohio State Fair in Columbus, August 27-September 2, in cooperation with the Ohio Department of Health.

5. An exhibit featuring the profession's campaign against compulsory sickness insurance at the Stark County Fair at Canton, September 5-10, cosponsored by the Stark County Medical Society.

6. An exhibit featuring progress in medicine at the Ashland County Fair, September 20-24, cosponsored by the Ashland County Medical Society.

←(Pictures on Facing Page.)

7. A campaign exhibit opposing compulsory sickness insurance at the annual meeting of the Ohio Society of Medical Technologists in Dayton, October 8. This group adopted a resolution putting it on record as opposing compulsory health insurance at this meeting.

8. An exhibit on maternal and child health at the Ohio Welfare Council in Cincinnati, September 26-30.

9. An exhibit on bones and muscles at the annual meeting of the Ohio Society for Crippled Children in Columbus, October 16-17.

10. An exhibit on Botulism was procured for the Highland County Health Council for the Highland County Fair, Hillsboro, September 7-10.

An exhibit on Brucellosis is being furnished the Cleveland Health museum for showing in November.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since August 1, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ASHTABULA COUNTY
John R. Higerd, Ashtabula

ATHENS COUNTY
Charles F. Jividen, Athens

CLARK COUNTY
H. V. Allen, Jr., Springfield

CUYAHOGA COUNTY
E. B. Beery, Euclid
Stacey A. Besst, Lakewood
Herbert C. Duber, Cleveland
Richard A. Elmer, Cleveland
Martin Epstein, Cleveland
Harry Goldman, Cleveland
Arnold L. Heller, Cleveland
Edward R. Hill, Cleveland
John A. Hudec, Cleveland
Julian Kassen, Cleveland
Milton John MacKay, Cleveland
Thomas L. Manning, Cleveland
James R. Nolan, Parma
Myron L. Pardee, Cleveland
Robert H. Reddick, Cleveland
John F. Whitman, Cleveland
Robert F. Williams, Cleveland

FRANKLIN COUNTY
Herbert K. Ervin, Reynoldsburg
Theodore J. Lukens, Worthington

HAMILTON COUNTY
Lawrence J. Gibbony, Cincinnati

LUCAS COUNTY
Theron L. Hopple, Toledo
Orrin C. Keller, Toledo
Christopher G. Palans, Toledo
David K. Scheer, Toledo
Robert B. Walker, Toledo

MAHONING COUNTY
Arnoldus Goudsmit, Youngstown
Vincent G. Herman, Campbell
William Newcomer, Youngstown
Charles E. Pichette, Youngstown
Charles W. Stertzbach, Youngstown
Durbin T. Yoder, Youngstown

ROSS COUNTY
Lewis W. Coppel, Chillicothe

WAYNE COUNTY
Robert A. Anderson, Wooster
William C. Beam, Orrville
John J. Butler, Wooster
John R. Loftis, Wooster
Lisle W. Roose, Smithville

Maternity Rooming-in Units

The Public Health Council at its June 25 meeting wrote into the Ohio Sanitary Code two changes in regard to rooming-in units maternity hospitals.

Regulation 87a provides permissive authority for the establishment of rooming-in units in maternity hospitals, while Regulation 90 as amended regulates the number of visitors to a patient in a rooming-in unit. Both provisions became effective August 25.

Half-Century Doctors Honored at Montgomery Meeting



Shown above at the 100th Anniversary Celebration of the Montgomery County Medical Society are 14 of the members who were presented 50-year pins and certificates in behalf of the Ohio State Medical Association. Left to right, sitting are: Drs. G. A. Hochwalt, Dudley Keever, F. A. Duckwall, James Farber, Charles E. Burgett and C. G. Rogers. Left to right, standing: Drs. C. E. Shawen (not a 50-year member), Roscoe R. Bond, Curtiss Ginn, John L. Carter, Charles W. Holtzmuller, A. H. Dunham, Pearl L. Gunckel, Edward B. Doan and Daniel E. Miller. Not present at the meeting were Drs. N. W. Cowden, Lillian J. McBride, George D. Gohn and H. H. Herman. (Mayfield Photos, Inc., Dayton)

A FEATURE of the 100th Anniversary Celebration of the Montgomery County Medical Society, was presentation of the Ohio State Medical Association's Fifty-Year Pins and Certificates to 18 members of the Society who have practiced medicine for 50 or more years (or graduated from a medical school 50 or more years ago).

Presentation of the pins and certificates was made by Dr. Merrill D. Prugh, Councilor of the Second District of the Ohio State Medical Association.

The pins and certificates were authorized by the House of Delegates and are being presented to all members of the Association, or former members, who began the practice of medicine 50 or more years ago. Present plans are to have presentations made by District Councilors at appropriate ceremonies arranged by county societies.

Dr. Prugh summed up the achievements of the 18 men who received the awards and said that they had practiced a total of 985 years. He also reviewed the changes in the practice of medicine which they had witnessed in their days.

Fourteen of the 18 fifty-year men were present at the meeting and received the pins and certificates in person. Four others were unable to be present. The 18 are:

LIST OF 50-YEAR DOCTORS

Dr. F. A. Duckwall, born 1852, three years after founding of Society, aged 97, graduated from medical school in 1877—75 years ago.

Dr. Dudley Keever, aged 90, longest record as a member of the Montgomery County Medical Society—59 years, graduated from medical school, 1884.

Dr. James Farber, aged 85, graduated from medical school in 1886.

Dr. C. G. Rogers, aged 82, graduated 1894.

Dr. Daniel E. Miller, aged 82, graduated in 1899.

Dr. Edward B. Doan, aged 80, graduated in 1899.

Dr. Pearl L. Dunckel, aged 78, graduated in 1898.

Dr. G. A. Hochwalt, aged 77, graduated in 1895.

Dr. Curtiss Ginn, aged 77, graduated in 1895.

Dr. John L. Carter, aged 77, graduated 1895.

Dr. N. W. Cowden, aged 77, graduated 1897.

Dr. Roscoe R. Bond, aged 76, graduated 1897.

Dr. Charles W. Holtzmuller, aged 75. graduated 1899.

Dr. A. H. Dunham, aged 75, graduated 1899.

Dr. Lillian J. McBride, aged 85, graduated 1894.

Dr. George D. Gohn, aged 77, graduated 1897.

Dr. H. H. Herman, aged 77, graduated 1897.

The response to Dr. Prugh's presentation was made by Dr. Curtiss Ginn, in the name of members of the Fifty-Year Club.

Dr. E. L. Henderson, chairman of the Board of Trustees and President-Elect of the American Medical Association, was a guest speaker of the occasion.

Dr. A. C. Ivy, vice-president of the University of Illinois, was a guest speaker of the evening.

The Founders Day celebration was attended by 310 members and guests.

PUBLIC EXHIBIT

In connection with the Anniversary, the Society also sponsored an exhibit entitled "100 Years Progress in Medicine," at one of the downtown buildings in Dayton. The exhibits included Surgery, Clinical Pathology, Pediatrics, Obstetrics and Gynecology and Internal Medicine.

The Surgery exhibit showed an authentic 1849 operating room scene, complete with mannequins, etc., all of which showed contrasts to a complete setup of a 1949 operating room.

The Pathology exhibit, besides including specimens, had demonstrations of preparing and cutting frozen sections.

The Pediatric Section had a visible display of the Rh Factor.

The Obstetrical and Gynecological Sections included the story of childbirth, done with the use of plaster models.

The Internal Medicine exhibit was on the theme of Coronary Thrombosis. Included in this exhibit was a stethoscope with an amplifier, where people could hear their own heart-beats. All visitors who requested were given an EKG without cost to them. General chairman of the exhibit committee was Dr. A. F. Kuhl.

Opinion of Attorney General

The Syllabus of Opinion No. 868 recently rendered by Attorney General Herbert S. Duffy is as follows:

(1) The board of trustees of a county memorial hospital is not required by law to grant discounts to soldiers, sailors and marines, but may, in the exercise of its discretion, do so. (2) Soldiers, sailors and marines, as provided for in Sec. 3137, G. C., include all former members of the Army and Navy, irrespective as to their term of service. (3) The term "of the county," as used in Sec. 3137, G. C., refers to residents of the county at the time of admission to the hospital.

Buckeye News Notes . . .

Cadiz—Dr. Dwight C. Pettay resigned as part-time Harrison County health commissioner.

Cincinnati—In recognition of his services to the Jewish Hospital a memorial plaque and picture of Dr. Samuel Elgart were unveiled at the opening of the hospital's new X-Ray Pavilion.

Cleveland—A portrait by Rolf Stoll of the Cleveland Institute of Art, was presented to Dr. John A. Toomey in behalf of 188 of his associates in the medical profession.

Columbus—Dr. Eric Ogden has been appointed professor and chairman of the Department of Physiology of The Ohio State University College of Medicine. He comes from the University of Texas, Medical Branch, Galveston, where he served in the same capacity.

Dayton—Dr. T. E. Newell denounced "socialized medicine" in a talk before the local Kiwanis Club.

Marion—Dr. Carl W. Sawyer was reelected president at the 27th annual meeting of the Harding Memorial Association.

Mt. Vernon—Dr. John C. Woodland was elected president of the Kiwanis Club.

New Philadelphia—Dr. C. Raymond Crawley, Dover, addressed a meeting of St. Joseph's Parent-Teachers Association.

Sandusky—Dr. Duane Love in September accepted temporarily on a part-time basis the post as city and Erie County health commissioner. Dr. F. E. Mahla, resigned as commissioner to accept a post with Lucas County.

Shiloh—Dr. Harry Wain, Mansfield, Richland County health commissioner, addressed members of the Richland County Pomona Grange, on the subject of sanitation problems.

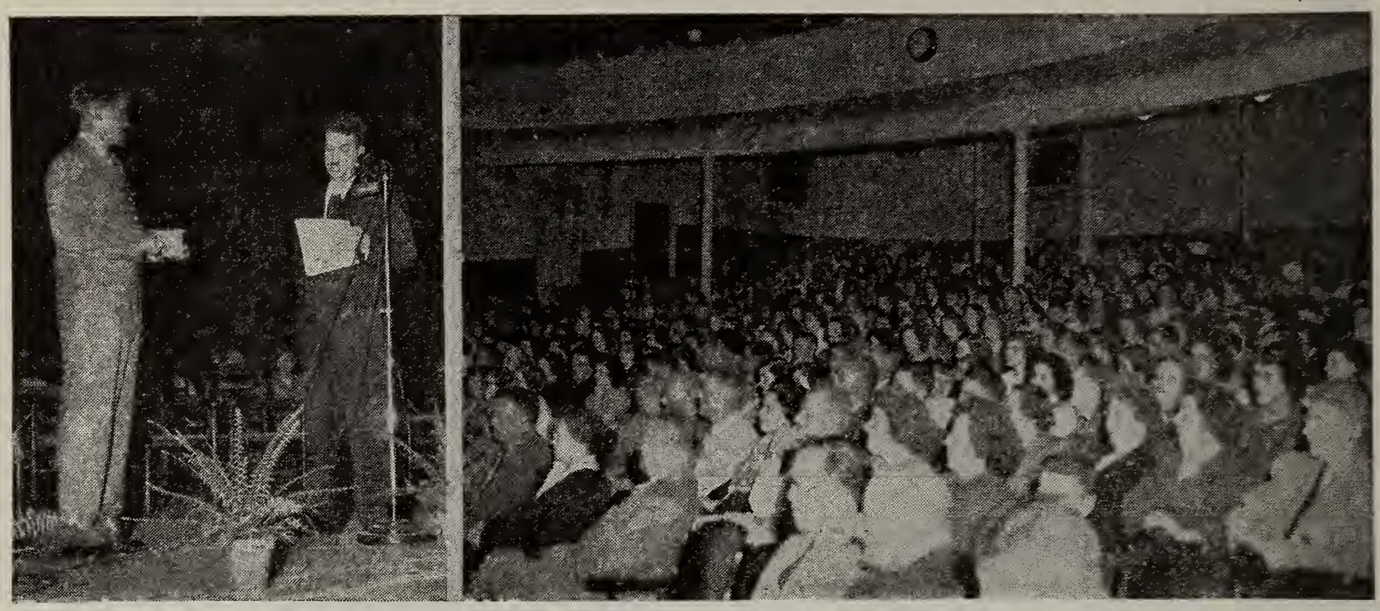
Toledo—Dr. John L. Stifel has been named chief of the staff of Toledo Hospital.

Uhrichsville—Dr. Elizabeth Aplin, Tuscarawas County health commissioner, explained health programs at a meeting of the Uhrichsville Buckeye Club.

Upper Sandusky—Dr. E. O. Swartz, President-Elect of the Ohio State Medical Association, and Dr. L. Howard Schriver, president of the Blue Shield Commission, both of Cincinnati, were guest speakers at an inter-community good-will ambassadors dinner.

Youngstown—"Modern Methods in Clinical and Laboratory Diagnosis of Heart Disease" was the topic discussed by Dr. Roy W. Scott and Dr. Harold Feil, Western Reserve University School of Medicine, at a meeting sponsored jointly by the Mahoning Academy of General Practice and the Youngstown Area Heart Association.

First of Association's Rural Medical Scholarships Presented



Dr. Carl A. Lincke, President of the Ohio State Medical Association, is shown presenting the scholarship to C. Craig Wright, in the presence of more than 600 4-H Club members and workers. (O. S. M. A. Staff Photos.)

The Ohio 4-H Club Congress of Ohio State University was the occasion for the presentation of the Association's first Rural Medical Scholarship on September 14.

Dr. Carl A. Lincke, Carrollton, President of the Association, and a country doctor himself, made the presentation of the first of four $500 checks to C. Craig Wright, Guernsey County farm youth, who entered O.S.U. College of Medicine as a freshman this fall.

Dr. Lincke's presentation speech was recorded and later broadcasted over Radio Station WOSU on the "Farm and Home Hour."

An additional scholarship will be awarded each year until the Association is sponsoring four rural young men or women at medical schools concurrently. The scholarship was created with the purpose of encouraging rural young men and women to take up the study of medicine with the hope that they will become country doctors and help supply the needs in rural areas.

Medical Women of Cincinnati

Newly elected officers of the Medical Women's Club of Cincinnati Branch 11, A. M. W. A., are: Dr. Margaret Schneider, president; Dr. Esther Marting, vice-president; Dr. Marjorie Grad, secretary; Dr. Bertha Dauch, treasurer.

The September 13 meeting was held at Meadowbrook, Venice, Ohio. Speaker was Dr. Betty Owens of Middletown whose subject was "Common Skin Lesions in Dermatology. Guests included women internes from several Cincinnati hospitals.

The November meeting is scheduled for the Vernon Manor Hotel. Officers will be installed and Dr. Grad will present a discussion on "Congenital Anomalies."

Dr. LaRocco Is Named to Ohio Public Health Council

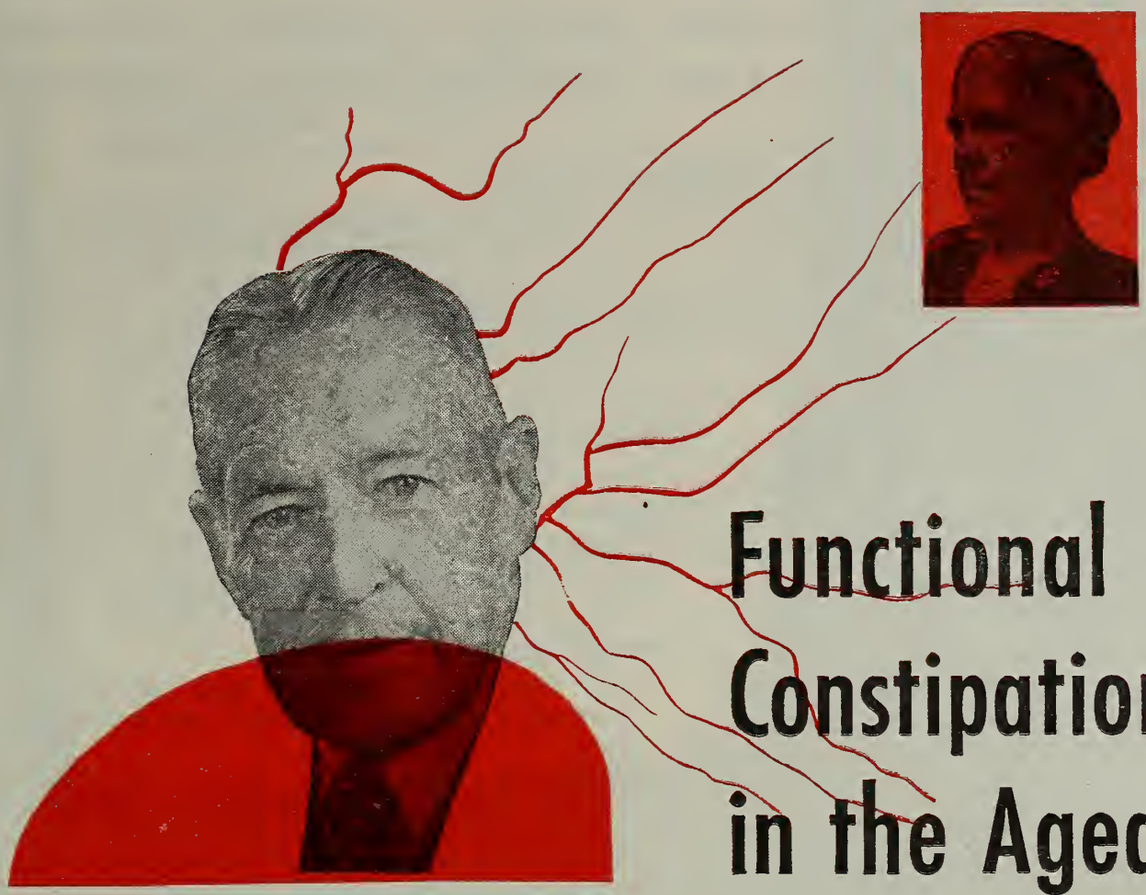
Announcement was made recently of the appointment by Governor Frank J. Lausche of Dr. Charles G. LaRocco of Cleveland to the Ohio Public Health Council. He was appointed to fill the unexpired term of Dr. L. F. Huffmann, also of Cleveland, who resigned. The term expires June 30, 1951.

Dr. LaRocco has been an active participant in activities of the Cleveland Academy of Medicine and has served as a delegate to the Ohio State Medical Association. He is a diplomate of the American Board of Dermatology and Syphilology and at present is assistant professor in the Department of Dermatology and Syphilology of the Western Reserve University School of Medicine.

He is a member of the American Academy of Dermatology and Syphilology. He is associate director and visiting dermatologist at St. Vincent Charity Hospital and consulting dermatologist at several other Cleveland hospitals.

Another appointee to the health council is Judson C. Schuler, Millersburg attorney and secretary of the Holmes County Chapter of the Ohio Tuberculosis and Health Association. He succeeds Mrs. Lilly Cooper of Findlay.

The Ohio Public Health Council is the rule-making body of the Ohio Department of Health and acts in a quasi-judicial capacity to that agency. Other members of the council are: S. F. Ridings, D. D. S., Greenville; J. Howard Holmes, M. D., Toledo; Howard A. Hines, pharmacist, Van Wert; Phillip T. Knies, M. D., Columbus; and William Helmer, Cincinnati. W. H. Veigel, chief of the Vital Statistics Division of the Ohio Department of Health, is secretary of the Council.



Functional Constipation in the Aged

"Constipation is very frequently found in people of climacteric age,.... In the vast majority of patients, constipation is probably due to improper habits, diet, or gastrointestinal disorders."*

The soft, demulcent, water-retaining, mucilloid bulk provided by Metamucil gently initiates reestablishment of reflex peristalsis and movement of the intestinal contents.

G. D. Searle & Co., Chicago 80, Illinois.

*Werner, A. A.: The Climacteric in Women and Men, Postgrad. Med. 4:102 (Aug.) 1948.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

Health Commissioners' Conference . . .

Chronic Illnesses, Environmental Sanitation, Equitable Distribution Of Federal Funds, Some of Points Discussed at Annual Get-Together

MEETING in Columbus, September 29 and 30, for their 30th annual conference with the Ohio Department of Health, Ohio's health commissioners received progress reports regarding the recommendations they adopted at last year's conference, and brought forth additional suggestions for future guidance of the department in dealing with local health units.

The opening general session was devoted to a panel discussion in which the division chiefs and other staff members of the State Department participated, and to a progress report, presented in behalf of the Department by Dr. A. B. Kurlander, Chief of the Division of Tuberculosis.

During the afternoon of the first day and the morning of the second, eight committees, comprised of local health commissioners, developed recommendations which were considered by the conference as a whole at the final session.

RECOMMENDATIONS ADOPTED

Those resolutions of interest to Ohio physicians include:

1. That the Ohio State Medical Association be invited to appoint a Committee on Chronic Diseases to counsel and advise on chronic illness control programs.

2. That all health departments cooperate with recognized medical groups, stressing the preventive phase of chronic illness through educational, case-finding, referral for diagnosis, and follow-up programs; and further, that in these programs emphasis be placed on preventive aspects and periodic examinations.

An amendment to the report of the Committee on Chronic Diseases, which would have put the Conference on record as favoring reportability of cancer, was voted down.

3. That the revision of the Communicable Disease Section of the Ohio Sanitary Code, suggested by the Ohio Department of Health, be recommended to the Ohio Public Health Council for approval, as amended by the Committee on Communicable Diseases of the Conference.

4. That Regulation 12 of the Sanitary Code, providing for placarding, be revised in conformity with the current recommendations of the American Public Health Association.

5. That a committee made up of various interested health agencies be formed as an advisory body to the Director of Health for the purpose of studying communicable disease problems in Ohio and making recommendations for control measures, including the problem of disease reporting.

6. That the Ohio Department of Health undertake a study to clarify the responsibility of local health departments and procedures to be followed by those departments in the isolation of recalcitrant cases of tuberculosis.

ENDORSE HEALTH UNITS MEASURE

The conference endorsed the Local Health Units Bill, now before Congress, and concurrently adopted a six-point program which they recommended for use in determining the eligibility of local health departments to grant-in-aid funds.

This program includes the following recommendations:

I. That distribution to local health departments be on a reasonable and equitable basis.

II. That a method of distribution be designed to distribute funds on a cash basis which would operate with a minimum of administrative difficulty.

III. That fiscal and administrative safeguards be established in order to assure that allocated funds are used in accordance with the spirit and intent of the grant.

IV. Eligibility Standards for participation in grants:

1. The local health department shall perform all duties and functions imposed on it by the statutes of Ohio, and by the rules, regulations and orders of the Ohio Department of Health.

2. The local health department shall maintain and operate a central office and headquarters on a full-time basis during the normal work week of the local units of government.

3. Those local health departments not already operating under an accepted civil service system shall adopt and operate under a merit system which shall be satisfactory to the Director of Health.

V. Basic personnel requirements:

1. Full-time doctor of medicine in charge of administration. (In accordance with Ohio Statutes, a full-time non-medical administrator is acceptable if local medical consultation is available.)

2. A staff to include one full-time nurse, a full-time sanitarian, and a full-time clerk or stenographer.

VI. That the local department offer or be prepared to offer as a result of the grant, at least the following basic services: Vital Statistics; Control of Communicable Disease services; Environmental Sanitation services; Maternal and Child Health services; Laboratory services; Health Education services; and Chronic Disease services.

The Ohio Department of Health was asked to

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set up a program of evaluating the various serodiagnostic tests used in the diagnosis of enteric and febrile diseases. Also to evaluate bacteriologic tests of water and milk in local health districts.

The continuation of the Venereal Disease educational program was recommended and the State Department was requested to give serious consideration to the establishment of industrial hygiene services in local departments.

ENVIRONMENTAL SANITATION

Resolutions concerning environmental sanitation were:

1. That the Sanitary Standards, or interpretation of Regulations 232 to 235, inclusive, of the Ohio Sanitary Code, as published by the Ohio Department of Health, be made a part of said code, thereby establishing minimum uniform standards for commercial camps.

2. That, to promote uniformity and to establish a proper minimum level of sanitary standards, the Ohio Public Health Council adopt basic sanitary regulations covering development of rural water supplies and the installation of rural sewage disposal.

3. That legal authority for licensing and inspection of sanitation of restaurants and other food and drink establishments be transferred from the office of the State Fire Marshall to the Ohio Department of Health. (A standing committee, composed of Drs. W. H. Gaskins, Clermont County, H. A. Moore, Butler County, and Ward Scott, D. V. M., Canton, was selected to work with the Ohio Department of Health in drafting such legislation for presentation to the next regular session of the General Assembly.)

5. That the Ohio Public Health Council incorporate sanitary regulations for swimming pools in the Ohio Sanitary Code.

6. That the Ohio Department of Health investigate the possibility of preparing minimum standards for meat inspection and exercising supervision of local meat inspection services.

7. That legislation prohibiting the sale of raw milk or raw milk products to the public and for the use of raw milk or raw milk products for human consumption in all institutions of the State, both public and private, be adopted, enforcement of such legislation to be the responsibility of local health departments under the supervision of the Ohio Department of Health.

OFFICERS RE-ELECTED

All officers of the Conference were re-elected for the forthcoming year, including: Dr. W. H. Hartung, Toledo Health Commissioner, vice-chairman; Dr. F. E. Mahla, Health Commissioner of Lucas County, and Dr. M. D. Ailes, Akron Health Commissioner, executive committee. Dr. J. P. Owens, Hamilton County Health Commissioner, is serving the second of a two-year term as secretary. Dr. John D. Porterfield, as State Director of Health, automatically serves as the chairman.

At the annual banquet of the conference, Dr. Herman E. Hilleboe, Commissioner of Health for the State of New York, talked on "The Health Commissioner and His Community."

Radiological Society Schedules Five-Day Program in Cleveland

The 35th Annual Meeting of the Radiological Society of North America, to be held in Cleveland, December 5 through 9, will feature the theme, "The Diagnosis and Treatment of Cancer." Headquarters for the program will be the Public Auditorium and the Statler Hotel.

The program was prepared with two purposes in mind, according to Dr. Edgar P. McNamee, Cleveland, president of the society: (1) To try to bring to the radiologist the 1949 thinking on the subject of cancer in the various parts of the body discussed in this program; and (2) to stimulate more interest in the cancer problem, not only in the specialty of radiology but in all other branches of medicine including the field of general practice.

The program will be a postgraduate course for anyone interested in cancer and should aid the educational program substantially for the medical profession in Ohio. All physicians of Ohio and surrounding states who are interested in the cancer problem are invited to attend the meeting. There will be no registration fee.

The program includes the following:

Monday morning, Dec. 5—New Development in the Cancer Field.

Monday afternoon—Symposium on Cancer of the Stomach and Symposium on the Treatment of Cancer of the Breast.

Tuesday morning, Dec. 6—Symposium on Roentgenologic Diagnostic Procedures in the Diagnosis of Tumors of the Small and Large Intestine and Symposium on Intrathoracic Tumors.

Tuesday afternoon — Symposium on Intrathoracic Tumors (continued) and Symposium on Epidermoid Carcinoma of the Upper Mucous Membrane Tract.

Wednesday morning, Dec. 7—Symposium on Bone Tumors.

Wednesday afternoon—Symposium on Pediatric Roentgenology and Tumor Conference.

Thursday morning, Dec. 8—Symposium on Tumors of the Urinary Tract.

Thursday afternoon—Symposium on Diseases and Tumors of the Skull and Brain and Symposium on Cancer of the Cervix and Uteri.

Friday morning and afternoon, Dec. 9—New Trends in Radiology Correlated with Research in Other Scientific Fields.

Always

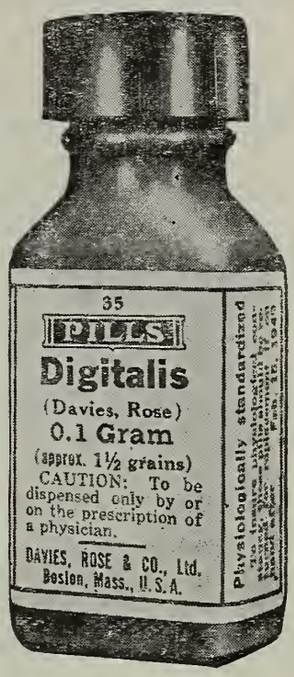
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D21

New Mental Hygiene Act . . .

New Forms For Admitting Patients to State Hospitals Now Available; Role of Physician Explained by Commissioner; Text of New Law Given

NEW forms for admitting persons to state institutions for the mentally ill, on a voluntary basis or without formal court commitment, under Amended House Bill No. 493, enacted by the 98th Ohio General Assembly, and effective September 24, are now available, Dr. Calvin L. Baker, state commissioner of mental hygiene, has announced.

The new forms may be secured from the Division of Mental Hygiene, Department of Public Welfare, Columbus; state hospitals, probate courts, county medical society secretaries and county and city health departments.

The medical certificate, Form "A," has been radically revised from the old system, Dr. Baker noted. Under Item 20, specific questions are asked concerning general diseases. One of the difficulties in the past has been lack of adequate medical information on patients being admitted, he said. Item 21 has been broken down into a rough psychiatric form of evaluation. Most physicians are aware of this material when they examine a patient, Dr. Baker said, but it is difficult for those who are not specially trained in the psychiatric method of examination to develop this outline.

TWO PHYSICIANS SIGN

Dr. Baker especially called attention to the fact that under the law, the two physicians who sign these medical certificates must be licensed by the State of Ohio and must have had at least three years in practice prior to signing.

Form "B" is the case history of mental illness, which should be filled out for the information of hospital authorities. Dr. Baker said that there is some question as to whether filling out of this form is the responsibility of the physicians who do the examination, but, he said, it is well for them to know that it will be required so that they can so inform the families.

Form "C" is the application which some member of the family or community must fill out and present to the two physicians called to examine and complete the medical certificate for the person presumed to be mentally ill.

Form "D" is the application form for admission to receiving hospitals by the patient himself. Under the law, there should be a certificate accompanying the patient and this yellow form, the provisions of which have not been too rapidly complied with in the past. The medical certificate, Form "A," will be required in the future.

Text of Amended House Bill No. 493 is as follows:

AN ACT

To enact sections 1890-III, 1890-IIIa, 1890-IIIb, 1890-IIIc, 1890-IIId, 1890-IIIe, 1890-IIIf and 1890-IIIg of the General Code relative to the commitment, admission, or detention of the mentally ill.

Be it enacted by the General Assembly of the State of Ohio:

Section 1. That section 1890-III, 1890-IIIa, 1890-IIIb, 1890-IIIc, 1890-IIId, 1890-IIIe, 1890-IIIf and 1890-IIIg of the General Code be enacted to read as follows:

Sec. 1890-III. In addition to the procedure otherwise provided by law for the commitment, admission, or detention of the mentally ill, such persons may be admitted to and detained in appropriate institutions or hospitals in accordance with the provisions of sections 1890-IIIa to 1890-IIIg of the General Code.

Sec. 1890-IIIa. Any person may be admitted and detained as a patient by the superintendent, chief officer, or physician in charge of the appropriate state hospital, state receiving hospital, or a private institution or hospital licensed by the division of mental hygiene of the Ohio department of public welfare for the observation, care, custody, or treatment of the mentally ill, or if such person is eligible for care or treatment by the United States veterans administration or other agency of the United States government, by the official in charge of any United States veterans hospital located within the state of Ohio, for a period not to exceed six months as hereinafter provided in this and the next six succeeding sections, upon the written request of any member of the family of such person, a friend, an individual with whom such person resides, any law enforcing officer of a township, village, county, or municipal government if such person has been taken into custody and placed in jail, or the superintendent, chief officer, or physician in charge of a county home, hospital, charitable institution, or a licensed agency, who has reasonable cause to believe that such person is mentally ill, provided that such person is examined by at least two physicians registered in Ohio, each of whom has had at least three years experience in the practice of medicine and neither of whom is on the staff of, or interested financially in, the institution or hospital to which it is sought to have such person admitted and provided further that such request is accompanied by a written medical report and a certification of such physicians that they have examined such person and have reasonable cause to believe that such person is mentally ill and requires hospitalization. Such written request, medical report, and certification shall be directed to the superintendent, chief officer, physician, or official in charge of the institution or hospital to which it is sought to have such person admitted

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**Reprints on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

and shall show that such examination was made not more than ten days prior to the admission of such person.

Sec. 1890-IIIb. At any time after such person has been admitted to such institution or hospital, he, or anyone in his behalf, may make a request in writing to the superintendent, chief officer, physician, or official for his discharge and said request shall be complied with after the receipt of the same unless said superintendent, chief officer, physician, or official has reasonable cause to believe that such person is mentally ill and in need of observation, care, or treatment requiring his further detention. In such event said superintendent, chief officer, physician, or official shall retain custody of such person, and within five days following the receipt of such request, said superintendent, chief officer, physician, or official shall file an affidavit as provided by section 1890-23 of the General Code in the probate court of the county in which said institution or hospital is located or in the probate court of the county wherein such person resides for the purpose of invoking the jurisdiction of the probate court as is otherwise provided by law for determining the mental illness of such person. The affidavit shall be accompanied by the written report and recommendation of the examining physician of such institution or hospital and copies of the request, medical report and certification referred to in section 1890-IIIa of the General Code.

Sec. 1890-IIIc. If such person has not previously been discharged, at the expiration of one hundred twenty days following his admission and whether or not a request has been made by him or any other person for his discharge, said superintendent, chief officer, physician, or official shall file an affidavit as provided by section 1890-23 of the General Code in the probate court of the county in which said institution or hospital is located or in the probate court of the county wherein such person resides for the purpose of invoking the jurisdiction of the probate court as is otherwise provided by law for determining the mental illness of such person. The affidavit shall be accompanied by the written report and recommendation of the examining physician of such institution or hospital and copies of the request, medical report and certification referred to in section 1890-IIIa of the General Code.

Sec. 1890-IIId. When an affidavit is filed by the superintendent, chief officer, physician, or official as provided by sections 1890-IIIb or 1890-IIIc of the General Code, it shall be filed, indexed and docketed in the said probate court in the same manner as a proceeding under section 1890-23 of the General Code. The hearing shall proceed in said probate court in the same manner after notice as is otherwise provided by law except that a warrant of detention need not be issued, and except that when an affidavit has been filed as required by section 1890-IIIc of the General Code, the probate court may adjourn the case for a period not to exceed sixty days, upon the recommendation of the examining physician of the institution or hospital in which such person is detained. Such person shall be detained at said institution or hospital until the matter has been heard and disposed of in accordance with section 1890-27 of the General Code. In the event that the superintendent, chief officer, physician, or official files the affidavit in the probate court of the county other than the county of the residence of such person, the probate judge of such court shall immediately notify the probate court of the county in which such person resides if such person is a resident of Ohio, and shall immediately transmit a certified copy of all papers filed in said proceedings to the probate court of the county in which such person resides, which papers shall be indexed, filed and docketed in such probate court.

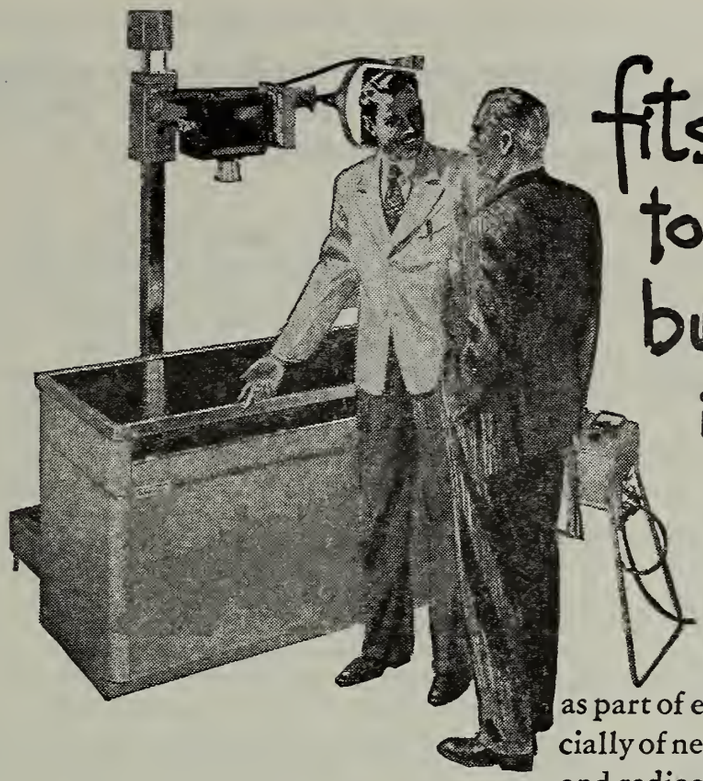
Sec. 1890-IIIe. After the admission of such person as provided herein, all provisions of law, except as otherwise specifically provided, shall be applicable, including the general provisions with respect to removals, trial visits, escapes, deaths, discharges, and returns of escaped or visiting patients, it being the intent of this section to provide only for an involuntary temporary admission procedure for the care, observation, or treatment of the mentally ill without resorting to a court proceeding in the first instance.

Sec. 1890-IIIf. All costs shall be the same as is otherwise provided by law, and all costs and fees shall be paid from the treasury of the proper county upon certification of the probate judge. The probate court shall be paid the sum of five dollars out of the county treasury upon the warrant of the county auditor which shall issue upon the certification of the probate judge and shall be in addition to the fees provided by section 10501-43 of the General Code.

Sec. 1890-IIIg. All forms necessary for the execution of the provisions of sections 1890-III to 1890-IIIg inclusive, of the General Code shall be uniform throughout the state and shall be prescribed by the division of mental hygiene.

At its Washington meeting October 3 - 4, the recently organized Water Pollution Control Advisory Board recommended to Surgeon General Leonard A. Scheele that the $200,000 appropriation which is available this year be concentrated on just a few river basins instead of being widely dispersed throughout the country. Also recommended were the "essentials" of a uniform state law for strengthening the pollution control activities by the several states. Formation of a technical committee to review prospective research projects was urged by the advisory group, which also endorsed continuation of special grants for study and research projects having sectional or national significance.

A 48-week course in practical nursing for WAC enlisted women currently assigned to the Army Medical Department has been announced by Major General R. W. Bliss, the Surgeon General, Department of the Army. The course, which is a direct responsibility of the Nursing Division of the Surgeon General's Office, will be conducted at Walter Reed General Hospital, Army Medical Center, Washington 12, D. C., and will extend from 17 October 1949 through 29 September 1950. Five Army Nurse Corps officers and an Army dietitian have been assigned to the faculty.



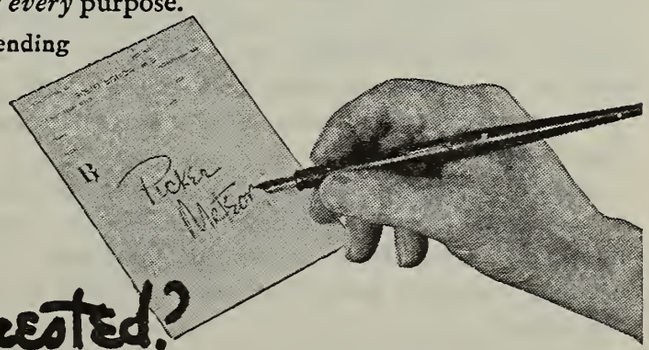
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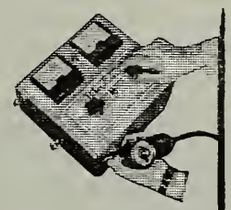
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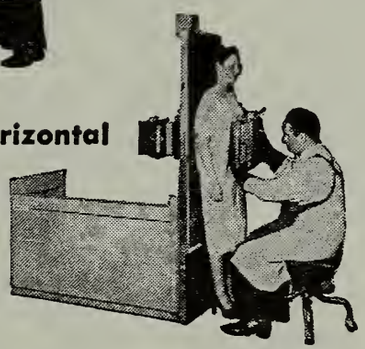
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

IF YOU AGREE, DO SOMETHING ABOUT IT

Congressmen L. C. Arends, Illinois, in answering a letter from a physician constituent, made this pregnant observation about doctors generally and the trend of the times:

> **"To my way of thinking, doctors are among the very most influential individuals in any community, since they not only work with people to cure their ills, but likewise, in many cases they are father advisers to patients, even in family troubles, etc. Therefore, my thought is that doctors should do something about politics, meaning that they are going to have to get into politics up to their necks whether they like it or not. Merely stating their opposition to compulsory health insurance to a few of their friends or sending the A. M. A. $25 to fight such a proposal is not enough. In other words, doctors are going to have to go into action on the political front."**

Similar views have been expressed by some of Ohio's congressmen and by a considerable number of Ohio physicians.

It's time for each physician to go into a huddle with himself on this matter. If he comes out convinced that the warning is correct, then he had better do something about getting into action at once.

MEDICAL-EDUCATION ANALOGY DEBUNKED

Frequently the proponents of socialized medicine use the public school system as an example of how well government can take over, run and control a public service, contending that the same thing can and should be done in supplying medical service.

Just how good or how bad a job has been done by government in the field of education is a moot question. One thing is certain, however: The analogy between education and medicine is unwarranted.

This point was stressed in a recent statement by Dr. Frank G. Dickinson, director of the Bureau of Medical Economic Research, American Medical Association, in which he debunked the comparisons drawn by those who want government to take over the medical services.

Dr. Dickinson charges that medical care in its entirety is so fundamentally different from education that there appears little or no basis for comparison:

"To point out any superficial likeness is to overlook the basic function of medicine, to disregard the real role of the physician, to lose sight of the very end to be desired—better medical care for the American people," he said.

"The fundamental difference between teaching and practicing medicine arises out of the fact that the teacher is concerned with a large, fairly standardized group of persons in a class or grade, while the doctor must of necessity be concerned with the individual. The public school teacher presents subject matter which is standardized to a large degree to a large class composed of children or young people of somewhat similar intellectual development who presumably enjoy normal health. Her primary purpose is to teach her students to do things for themselves. Education lends itself to group organization.

"The physician's interest must lie in the individual patient. The physician cannot administer the same treatment to a large group of persons—25 boys and girls in one class or grade. He must diagnose each case separately and select the proper treatment for each patient. From infancy to old age the medical needs of an individual undergo continual change and the doctor must be able to administer medical treatment to people of all age groups. He is concerned with the differences, not the similarities in persons.

"The physician, if he is to perform his work at all, let alone maintain a high quality of medical care, cannot offer a standardized product. His services are not adaptable to government regulation and organization, to fixed rules and basic standards—the necessary concomitants of any national compulsory scheme. In fact, the physician would be rendered powerless to fulfill his primary obligation to his patient if condemned to such uniformity."

Dr. Dickinson admitted the government can function efficiently in public health services involving problems of sanitation, the water supply, food handling in public eating places, communicable diseases and similar matters which concern large groups of persons.

WHY WAIT LONGER? PAY A. M. A. ASSESSMENT NOW

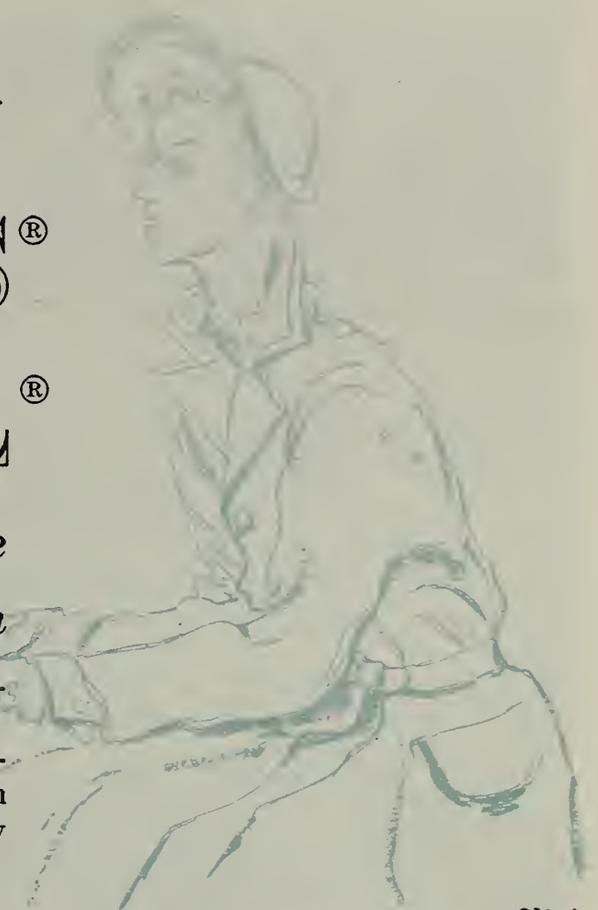
Commenting on failure of a portion of members to pay the A. M. A. assessment, *Philadelphia Medicine*, official magazine of the Philadelphia County Medical Society, said:

"This means that about one-third of the members of the County Society are satisfied to have the remaining two-thirds of their confreres literally fight this battle for them. If this same one-third would only realize that the present fight against socialized medicine is being fought on behalf of all physicians and their patients their attitude might be entirely different."

Doubtless many of the unpaid one-third in Philadelphia are like many of the unpaid in Ohio—procrastinators. Nevertheless time is

for Contraception
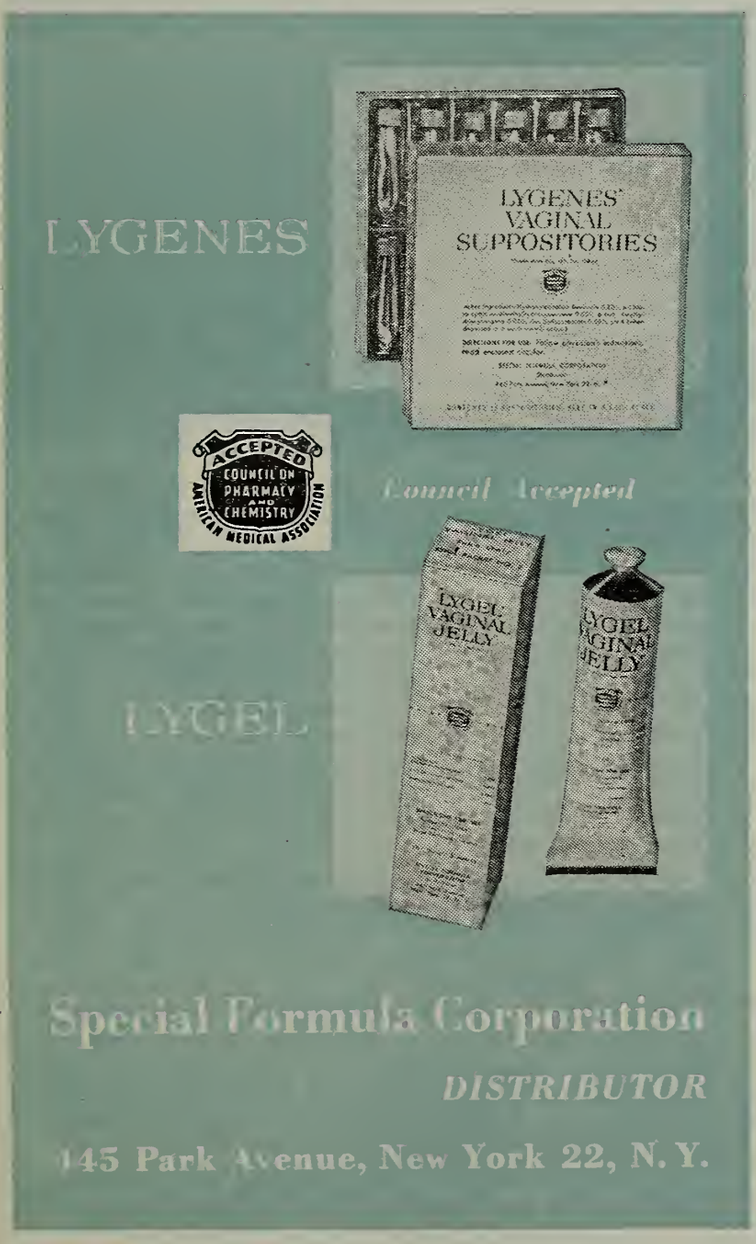
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marching on. This situation needs instant correction—and we don't mean in Philadelphia, but in Ohio.

Lists of members of the State Association who have **not paid** the assessment are being sent to County Society officers and District Councilors, by order of The Council, for follow-up procedures. Why wait, if you haven't paid, for someone to see you? Send in your check now to the Columbus Office.

ONE SOLUTION FOR COSTS OF HOSPITALIZATION

"If the cost of hospitalization continues to rise, these benevolent institutions will eventually consume themselves and their patients with them. It reminds us of Charles Lamb's 'Dissertation on Roast Pig.'"

The above is quoted from an editorial in the *New York State Journal of Medicine*, which continues as follows:

"We have a remedy to propose. Appoint to every hospital an *Advocatus Diaboli*. He could be an older man of wide clinical experience, attached to the resident in charge of medicine or surgery. He will never leave the side of the unhappy young man. When the resident calls for a 'full work up' on such and such a case, before the patient has been seen by either the attending physician or surgeon, the *Advocatus Diaboli* will ask him what is the significance of such and such a test? Why is it necessary in this particular case?

"In the course of such proceedings the older man will learn a great deal about the most modern laboratory tests. The resident will learn how to do without them by the use of the five senses that God gave him. It will be a process of highly beneficial mutual education.

"In the course of it the hospital will save a great deal of money.

"The *Advocatus Diaboli* would never order a laboratory test without asking himself how much it was going to cost the patient and was such an expenditure essential to the diagnosis of the case. He would be as nice in his judgment in recommending a 'G.I. series of X-rays' as if he were ordering them for his own wife, and as if he had to pay for them.

"According to our prescription the older man would be brought up to date on a number of tests of which he had never heard, and without which he and his patients had been getting along quite well.

"The resident would learn that the employment of his five senses would open to him delightful fields of research that the laboratory could never offer him. He might learn that a well-taken history could shed more light upon his patient in the psychosomatic field than could any X-ray or microscope.

"And during the process of mutual education both hospital and patients would save considerable money."

In our opinion, the above hits the nail on the head. Until something is done to simplify procedures and reduce the frills, the situation will only grow progressively worse.

WHAT ARE YOU DOING ABOUT IT?

"You cannot bring about prosperity by discouraging thrift. You cannot strengthen the weak by weakening the strong. You cannot help the wage earner by pulling down the wage payer. You cannot further the brotherhood of man by encouraging class hatred. You cannot help the poor by destroying the rich. You cannot establish sound security on borrowed money. You cannot keep out of trouble by spending more than you earn. You cannot build character and courage by taking away man's initiative and independence. You cannot help men permanently by doing for them what they could and should do for themselves."

The above is not a quotation from the speech of some present-day "economic royalist." It's from one of the addresses of Abe Lincoln. To say that it still holds true is putting it mildly, indeed.

What do you think ought to be done to stop the present trend toward the very things against which Lincoln warned? In fact, what are you doing about it?

ACTIONS NOT JUST PROMISES AND WORDS

Over in Evansville, Ind., the medical society is doing something about public relations. They admit it and have the facts to prove their statement.

Here's what they say in a little pamphlet called, "We're Doing Something About Public Relations in Vanderburgh County," to which we add a fervent "Amen" and the suggestion to each medical society that it go and do likewise:

"The Vanderburgh County Medical Society has quit talking about Public Relations and is doing something about them.

"This society has developed an active program of interest in community affairs based upon the obligations and responsibilities of citizenship. We are not doing things for our community because we expect to get back a tangible reward in good will. We are contributing our time, energy and money because we believe it is our responsibility as citizens to do everything we can to make Evansville and Vanderburgh County a better place in which to live, to work and to raise our families.

"We have shaken off the old ultra-conservatism that kept medical societies from participating in community progress. We are no longer aloof and indifferent to everything except the daily care of the sick. We are vitally interested in what goes on in Evansville and Vanderburgh County and we are taking an active part in making a better community. We are providing the leadership and guidance in health matters which is our responsibility as citizens and which our community expects of us.

"More and more of our doctors are accepting membership on boards and committees of com-



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Creamalin, the first aluminum hydroxide gel, readily and safely produces sustained reduction in gastric acidity. With Creamalin there is no compensatory reaction by the gastric mucosa, no acid "rebound," and no risk of alkalosis. Through the formation of a protective coating and a mild astringent effect, nonabsorbable Creamalin soothes the irritated gastric mucosa. Thus it rapidly relieves gastric pain, speeds healing of peptic ulcer and helps to prevent recurrence.

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munity organizations, particularly in the health and welfare fields. Our contributions to the Community Chest have doubled in the last two years. By giving generous financial support to community enterprises in addition to our charity services, we are standing on our own feet.

"We are constantly on the alert for new and better ways to improve medical care and community health. Society officers, committees and the membership are working harder than they ever worked. The number of society programs and projects for community betterment are growing.

"We do not measure what we do by the Public Relations yardstick. We don't use the term 'Public Relations' too often. But we do know that there is developing in our county an attitude of growing respect for the medical profession and the Medical Society, and greater confidence in our individual members as physicians."

"BELCHER'S LAW OF WELFARE DYNAMICS"

In a recent issue of the *Saturday Evening Post* appeared this intriguing item, carrying the heading, "Belcher's Law of Welfare Dynamics":

> **"In galloping through a business analysis by Paul E. Belcher, published by the First National Bank, of Akron, Ohio, we ran into a sentence which ought to go places:**
>
> **" 'The trend toward a welfare state . . . will end whenever more than half the voters are required to pay for benefits they themselves do not get.'**
>
> **"This statement ought to be dignified as Belcher's Law and be put into textbooks on economics. We are now in the phase where the good shepherds of the welfare state hope to keep the majority contented by extracting the bulk of the dough from the minority. When the minority runs out of funds, the test of Belcher's Law will be at hand."**

The sad feature of this story is that before Belcher's Law can be enforced lots of honest-to-goodness people, including most of those who are getting the benefits, are going to be hurt—and badly. The only hope is that maybe folks will wake up sooner than might be expected to the wisdom of Belcher's Law and demand a return to sanity.

PARADOX OF GOVERNMENT EMPLOYEE AND FREE CHOICE OF JOBS

Advocates of socialization (of medicine or otherwise) might take cognizance of the turnover of personnel in governmental offices and ask themselves how this would be condoned under complete government control.

It is a well known fact that the turnover of personnel in many government agencies—both State and Federal—is high.

The irony of this situation is that government employees are enjoying to the full the good old free enterprise system right in their government jobs. If an employee is not satisfied with his lot he merely quits and either goes to some other government agency or finds non-government employment. Although the turnover in more responsible positions is not as great, the same principle still prevails. True, many government workers are efficient and contented, but they are contented because they gained and maintain their jobs under a system of free enterprise. Government officials also know that they must compete with a free enterprise system if they wish to keep their employees satisfied.

But what would be the situation under complete socialization, or even under a system strong enough to dominate the employment field in one (medicine, for example) or a number of occupational fields? Without competition from an outside free enterprise system, would the government permit employees to go and come as they pleased? Where could they turn for advancement? The answer is obvious.

The employee would be little better than a slave, being advanced only on the approval of his immediate superiors or on the whim of political bosses higher up. A system might be worked out to advance the efficient and to distribute others according to their aptitudes, but no such system could satisfy the human element which now largely determines whether a person will stay or go elsewhere.

Unfortunately, many of the advocates of socialization (and those who are indifferent to its encroachments) never attempt to project their thinking into a situation in which the government would have complete control without outside competition, and its effect on the morale and economic status of the employees.

ONE OUT OF EIGHT A PUBLIC EMPLOYEE

One out of every eight or nine persons employed in the United States today is a government worker, according to a recent report of the National Bureau of Economic Research.

This report brought forth the following questions from an editorial writer with the *Cleveland Plain Dealer*: Are all the functions these people perform necessary? Can our economy afford the present volume of government employment? Are functions considered necessary being performed efficiently?

Good questions, in our opinion. Doubtless, you'll agree. But, are you doing anything about it—such as writing your Congressman, indicating your alarm and asking him to rescue our economy from the brink where it is now perched? What's the use of all the crabbing unless citizens (you, in particular) do something about it?

Columbus Blood Center Unit Cost Second Lowest in Nation

The Columbus Red Cross Regional Blood Center is processing blood at the second lowest cost per pint of any of the thirty-three blood centers now in operation throughout the United States. This report was made public by Alfred L. Baron, executive director of the Franklin County Chapter.

From January 1 to June 30, the 11,042.5 pints of blood collected both at the Columbus Center and from the 26 participating counties were processed at a cost of $7.44 per pint. The only center processing blood at a lower cost is the center in Wichita, Kansas.

As the Columbus Regional Center was the 18th to be put into operation by the American Red Cross, the report shows that it is operating at a lower cost than those first established as well as those opened later—some in cities much larger than Columbus.

In computing the cost of processing a pint of blood, the recruitment of the donor, the collection of blood and its distribution are taken into consideration. As the number of donors increases, the cost of the blood, per pint, decreases.

By July 1, 1950, the National Red Cross expects to have 44 centers in operation across the nation. The ultimate aim is a chain of 140 centers, covering every section of the United States.

Mr. Baron estimates that with the number of donors increasing monthly, the Columbus Center can look forward next year to the processing cost being lowered to $5.00 per pint.

The main reason for the low processing cost, according to Mr. Baron, is the large number of volunteers serving at the Center. Between 100 and 125 women and men are on duty at the Blood Center each week.

The Columbus Regional Blood Center now covers a 26-county area, with two additional counties entering the program December 30. Logan County will start its program in November and Perry County in December, bringing the total number of participating counties to 28.

The number of donors at the Columbus Center reached a new high during the month of September with 1,188 persons presenting themselves and 1,009 pints of blood collected.

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting in Houston, Tex., March 9-11, 1950.

State Medical Board Takes Action in Three Cases

The State Medical Board at its meeting in Columbus on October 4, took action in the case of three practitioners, Dr. H. M. Platter, secretary, announced.

The Board revoked the certificate of Ernest A. Craig, M. D., of Cincinnati, following his conviction on a felony charge. Dr. Craig has appealed to the Common Pleas Court of Hamilton County.

The Board indefinitely suspended the certificate of Florian N. Domalski, M. D., Toledo, for alleged narcotic addiction.

The Board indefinitely suspended the certificate of John W. Schenz, Columbus, mechanotherapist, for engaging in the general practice of medicine though licensed as a limited practitioner. Schenz has appealed his case to the Common Pleas Court of Franklin County.

The next examination for applicants to practice in Ohio will be held in Columbus December 12-14. The written examinations will be given at the Deshler-Wallick Hotel and the practical and clinical examinations at the Ohio State University College of Medicine.

Grants in Heart Research

A total of $8,614,737 in Federal funds was awarded to 85 medical schools and research institutions in 34 states and the District of Columbia, an announcement from the Federal security administrator stated.

Administered by the National Heart Institute of the Public Health Service, the funds will be used for stepped-up heart research, for expanded programs of heart teaching in medical schools, and for building additional heart research laboratories throughout the country.

Included in the grants are the following in Ohio:

University of Cincinnati, Johnson McGuire, "Form of the ballistocardiogram in health and disease," $10,800; and expanding present training program, $12,500.

University Hospitals of Cleveland, William D. Holden, "Quantitative determination of blood proantithrombin," $2,500.

Western Reserve University School of Medicine, R. W. Eckstein, "To determine the cause of increases in coronary blood flow following stimulation of the cardiac accelerator nerves," $9,227.

Western Reserve University School of Medicine, Lorand V. Johnson, Max Miller and J. Lowell Orbison, "Study of retinal vascular diseases in diabetes," $2,400.

Do You Know? . . .

Guest speakers at the annual scientific assembly of the Medical Society of the District of Columbia, Oct. 17-19, at Washington, D. C., included Dr. Edward A. Gall, Cincinnati, who spoke on "What Is Early Cancer?" and Dr. Bruce K. Wiseman, Columbus, who discussed "Hypersplenism."

* * *

The Statistical Bulletin of the Metropolitan Life Insurance Company estimates that there will be about 1,600,000 marriages in the United States in 1949, about 12 per cent less than the total of 1,815,000 recorded in 1948. The decrease represents a continuation of the downward trend since 1946, when marriages in the country reached the all-time record of nearly 2,300,000.

* * *

Dr. Charles A. Doan, Dean, Ohio State University College of Medicine, spoke on "Advance in the Recognition and Therapy of Hematologic Diseases," at the annual meeting of the Kentucky State Medical Society, held at Owensboro, Oct. 6-8.

* * *

Officers of the American Congress of Physical Medicine for 1950 include: Dr. Walter M. Solomon, Cleveland, Second Vice-President, and Dr. Walter J. Zeiter, Cleveland, Executive Director.

* * *

The Federal Security Agency has announced that medical schools, hospitals and research institutes in 34 states and the District of Columbia have been awarded $8,614,737 in Federal grants for heart research, the funds to be administered by the National Heart Institute. This is in addition to $1,200,000 awarded for heart research last July. Among the new grantees is University Hospitals of Cleveland, $25,000.

* * *

The Senate Committee on Labor and Public Welfare has issued a two-volume transcript of testimony presented before the committee last May and June on compulsory health insurance, subsidization of medical education, voluntary prepayment plans and other issues involved in pending health education. Copies of the hearings may be obtained, as long as the supply lasts, without charge on request to the Committee, United States Capitol, Washington 25, D. C.

* * *

The American Society of Anesthesiologists is sponsoring refresher courses in anesthesiology for general practitioners, particularly those in rural areas. For complete details write Stevens J. Martin, M. D., Chairman, Committee on Medical Schools and Post Graduate Education, St. Francis Hospital, Hartford 5, Conn.

Dr. Louis G. Herrmann, Cincinnati, was one of the guest speakers at the annual assembly of the Omaha Mid-West Clinical Society, Omaha, Nebr., Oct. 24-28. He discussed: "Nonmalignant Surgical Lesions of the Colon."

* * *

The Surgeon General of the Air Force Medical Service, Maj. Gen. Malcolm T. Grow, has appointed 20 civilian physicians representing different fields of medicine as consultants to the Air Force Medical Service. The appointees include: Dr. Herbert B. Wright, Cleveland, urology, and Dr. Phillip T. Knies, Columbus, internal medicine.

* * *

Provisional figures on maternal mortality in the United States for 1948 show a rate of 1.2 maternal deaths per thousand live births, compared with 1.3 in 1947 and 6.2 in 1933. The rate for Ohio was 0.9 in 1948, 1.2 in 1947, and 6.1 in 1933.

* * *

Funds appropriated to the United States Public Health Service have increased almost 15 times in ten years. The total appropriations for the fiscal year 1938 were $13,146,980, and for the fiscal year 1948 they were $192,848,100.

* * *

Dr. John Cronin, a native Ohioan and graduate of the University of Cincinnati College of Medicine, has been appointed chief of the Division of Hospital Facilities, Public Health Service of the Federal Security Agency. He has been with the Public Health Service since 1934 and from 1947 until his recent appointment, was chief of the Federal Employee Health Division.

* * *

According to the 1948 Annual Vital Statistics Report of the Ohio Department of Health, 572 babies were born to mothers 15 years old or younger. One of the mothers was 11 years old, and nine were 12 years old. Ninety-one babies were born to mothers 46 to 49 years old inclusive.

* * *

The National Society for the Prevention of Blindness will hold a five-day conference in conjunction with the Interim Session of the Pan-American Association of Ophthalmology, March 26-30, 1950, at Miami Beach, Fla.

* * *

Dr. Jerry C. Price, New York, known to Ohio residents through the demonstrations of treatment of epilepsy which he has conducted for three years, has moved to Los Angeles, Calif., according to an announcement by Walter B. Underwood, executive director, of The Ohio Society for Crippled Children.



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	$ 5,000	Cash, and $400 monthly first 2 years, $300 monthly thereafter. Adjusted benefits for disabilities occurring after age 60.

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On the Firing Line . . .

Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"The Royal Free group of hospitals in London, which cost £128,000 to run in 1938, will shortly ask the Health Ministry to approve a £1,200,000 bill for its first year under the National Health Scheme. . . . This is the first hospital to show how costs have gone up, since the Health Service began last July. In 1947, £361,000 was spent, less than a third of the past year's bill."—*HOSPITAL COSTS UP TEN TIMES, in The London Daily Express.*

* * *

"British doctors are too busy or too tired to keep up to date professionally through medical journals, postgraduate courses or scientific meetings." — *William Alan Richardson, editor of Medical Economics.*

* * *

"If this country is hell-bent for federalization of everything, perhaps the next logical demand is for government-supplied victuals and federal food stores for everyone. Surely food is essential to the public health! And with constantly multiplying laws to live by, government lawyers for everyone are going to be a necessity."—*Clarence A. Jackson, Executive Vice-President, Indiana State Chamber of Commerce.*

* * *

In a discussion of German medical crimes, the *Journal of American Insurance* states that . . . "they are pointed out to call attention to the fact that there is a great deal more to medicine than the scientific knowledge required. No one can be more dangerous than the educated man who has lost the sense of responsibility and his ethical standards. If there really is a possibility that adoption of a system of state medicine could result in even a fraction of such degeneration in the American medical profession the subject is worthy of very close scrutiny."

* * *

"After having, since the war, run through more than six billion dollars of the American people's money, resources and produce, the British Socialist government finds itself in worse shape, in some respects, than ever . . . they advertise their planned economy as the way out of economic uncertainty and toward economic security and stability. For all their chatter and waste, they have neither security nor stability."—*The Columbus Dispatch.*

"One of the worst mistakes that can be made about medical care is to look upon it as a commodity. It no more lends itself to being a commodity than does religion because it is on the very next shelf to religion in its closeness to the lives of human beings."—*Frank H. Lahey, M. D., former president of the American Medical Association.*

* * *

"Well over a billion dollars of the cost of the health system is paid out of general taxation. It is one reason why British pay the world's highest income and sales taxes. Indirectly, it is a factor in the high costs which have cut sales of British goods in world markets."—*UTOPIA ON THE ROCKS, by E. T. Leech, Editor, The Pittsburgh Press.*

* * *

"In choosing a method of medical care which will accomplish our objective, we must have in mind the effect of the system of medical economy on the quality of medical service. Nor can we ignore the cost of any new system. The catastrophic effects of illness cannot be avoided by creating a catastrophic bankruptcy."—*Insurance Economics Surveys.*

* * *

"Although the (British) government promised to preserve the confidential doctor-patient relationship, thousands of intimate case records are now passing through the hands of government clerks. No doubt more than one clerk has thus been able to read the full details of his neighbor's miscarriage."—*William Alan Richardson, editor of Medical Economics.*

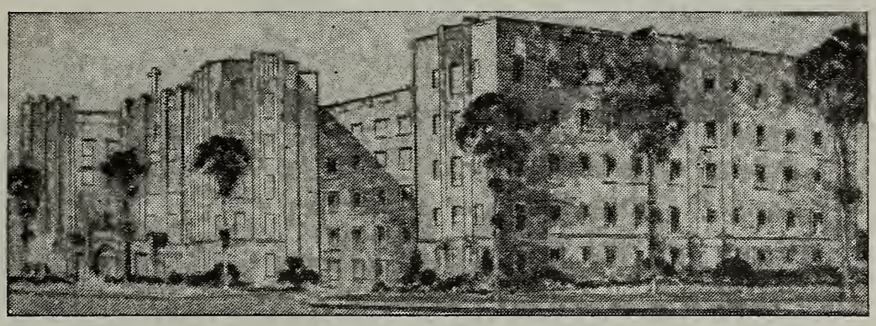
* * *

"Possibly, another ideology could do better in the next one hundred and seventy-three years. But I suggest we had better continue to suffer certain evils of free men and the ideal of equal opportunity than to die of nostalgia."—*Herbert Hoover.*

* * *

"I studied medicine for four years in Glasgow, and then took up engineering. I was sorry to give up medicine at the time, but now I'm glad I'm not a doctor. They are really in a tough spot."—*British executive interviewed by John W. McPherrin, Editor of American Druggist.*

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In Memoriam . . .

Russell Brooks Bailey, M.D., Wheeling, W. Va.; University of Cincinnati College of Medicine, 1922; aged 51; died September 22; member of the West Virginia Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Surgery; member of the Southeastern Surgical Congress and the American College of Surgeons. Dr. Bailey practiced in adjoining areas of Ohio as well as in Wheeling.

Paul Eberhart Barckhoff, M. D., Long Beach, Calif.; Bellevue Hospital Medical College, New York City, 1888; aged 88; died September 16; former member of the Ohio State Medical Association through 1934 and a member of the American Medical Association. Dr. Barckhoff practiced in Salem before moving to California in 1938.

John Francis Barker, M.D., Huntington, W. Va.; University of Kansas School of Medicine, 1934; aged 44; died September 30; member of the West Virginia Medical Association and a Fellow of the American Medical Association; member of the American Urological Association. Surviving are his widow, three sons and a daughter.

Emma Jane Betow, M.D., Clyde; Southwestern Homeopathic Medical College and Hospital, Louisville, Ky., 1904; aged 75; died September 24 at the Methodist Home in Elyria. Dr. Betow was a medical missionary in China for approximately 30 years beginning in 1904. Surviving are a brother, four sisters and a foster daughter.

Arthur Mansfield Brown, M.D., Erlanger, Ky.; State University of Iowa College of Medicine, 1920; aged 67; died October 4. Dr. Brown was a member of the staff of the Veterans Administration Center in Dayton from 1934 to 1945 and was later affiliated with the V.A. office in Cincinnati; surviving are his widow, three daughters, a son, three sisters and two brothers.

Alfonso Carfagna, M.D., Cleveland; University of Genoa Faculty of Medicine, 1912; aged 64; died September 25. Dr. Carfanga practiced medicine in Cleveland for approximately 35 years. He was a member of the Sons of Italy and the Catholic Church. Surviving are his widow, two sons.

Lawrence Amos Connell, M.D., Orwell; Ohio Medical University, Columbus, 1898; aged 72; died September 23; former member of the Ohio State Medical Association and the American Medical Association through 1943. Dr. Connell had practiced medicine for approximately 45 years and was Trumbull County health commissioner from 1921 to 1945. Surviving are his widow and a sister.

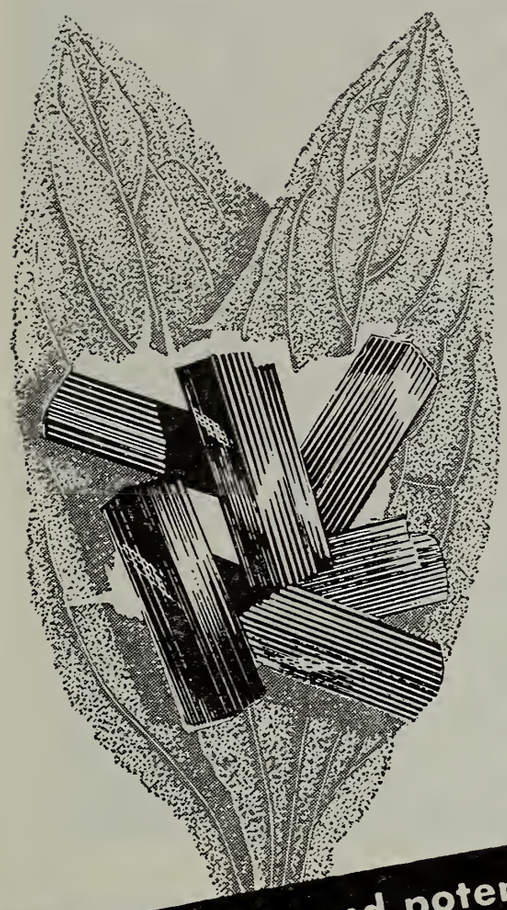
Louis M. Harris, M.D., Columbus; Ohio State University College of Medicine, 1912; aged 58; died August 31 in New York while on a vacation trip; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Harris had been in the practice of medicine in Columbus from the completion of his medical education. He was a veteran of World War I and was at one time Franklin County coroner. He was a member of several Masonic Orders, the Winding Hollow Country Club and B'Nai B'Rith Hillel Foundation. Surviving are a daughter, a brother and three sisters.

Thomas Evans Jones, M.D., Cleveland; Western Reserve University School of Medicine, 1916; aged 57; died September 29; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Surgery; member of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, American Surgical Association, Eastern Surgical Society and the American College of Surgeons. Dr. Jones was chief of the surgical staff at Cleveland Clinic. He was a veteran of World War I. Surviving are a sister and two brothers, one of whom is Dr. John Jones of Los Angeles, Calif.

Charles Richards Keyser, M. D., Van Wert; Starling Medical College, Columbus, 1900; aged 74; died September 14 in Ontario, Canada, while on a vacation trip; member of the Ohio State Medical Association and the American Medical Association; president of the Van Wert County Medical Society in 1924, its secretary-treasurer, 1919-23, chairman of legislative committee in 1928 and 1931 through 1945; delegate to the Ohio State Medical Association in 1933. Dr. Keyser had practiced medicine in Van Wert since 1912. He served as county health commissioner continuously from 1920 and for the past two years also was city health commissioner. In addition to his medical work, he was a sports enthusiast. Surviving are his widow, two sons and a brother.

Charles J. Krehbiel, M. D., Dayton; Pulte Medical College, Cincinnati, 1897; aged 78; died September 27. Dr. Krehbiel began practice in Dayton upon completion of his education and for many years operated a drug store. Surviving are a daughter, a son and a brother.

John Dryden McBride, M.D., Hillsboro; Cincinnati College of Medicine and Surgery, 1901; aged 74; died September 28; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Highland County Medical Society in 1918 and



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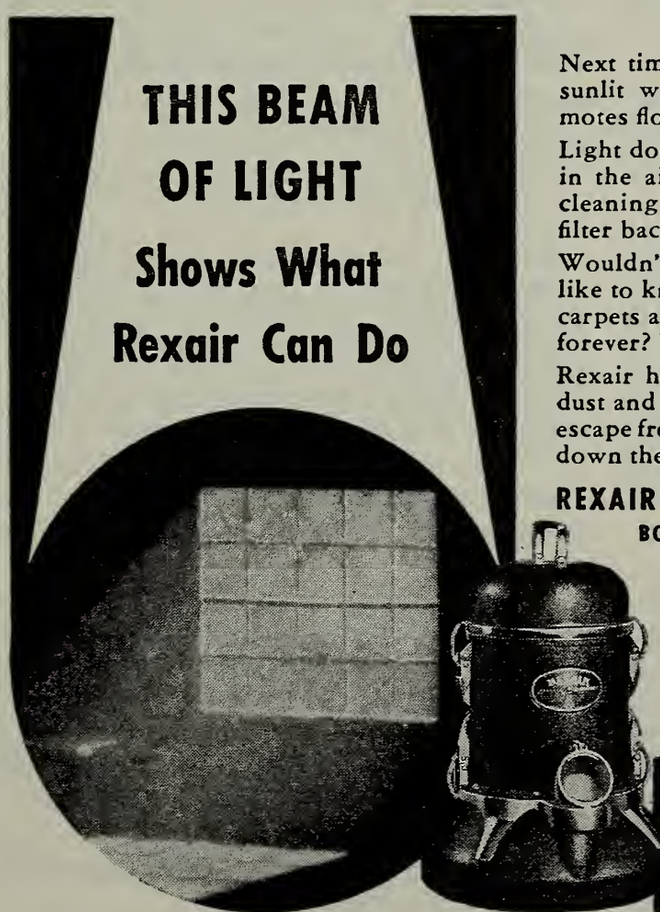


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1937 through 1946 and its president from 1923 through 1931. Dr. McBride had practiced medicine in Hillsboro for nearly 50 years. Surviving are his widow; two sons, Dr. Leland D. McBride, also of Hillsboro, and Dr. John R. McBride, Scott Field, Ill., and two brothers.

Myron Eli Millhon, M.D., Columbus; Jefferson Medical College, Philadelphia, 1923; aged 55; died September 28; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Millhon had practiced since 1923 in Columbus where he was associated professionally with his brother, Dr. William F. Millhon. He was a member of Sigma Alpha Epsilon and Alpha Kappa Kappa, and several Masonic orders. Surviving are his widow, two sons, two sisters and his brother.

Byron Hubern Nellans, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1914; aged 57; died October 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Nellans had been superintendent of the Hamilton County Home and Chronic Disease Hospital since 1945 and previously had been medical director. He was a veteran of World War I. Surviving are his widow, a son, a daughter and his mother.

Herbert Roscoe Pearson, M.D., West Milton; Baltimore Medical College, 1893; aged 81; member of the Ohio State Medical Association and the American Medical Association; president of the Miami County Medical Society in 1919, and delegate to the Ohio State Medical Association in 1918. Dr. Pearson had practiced medicine in Miami County for approximately 55 years. He was president of the Citizens National Bank of West Milton, was a member of the West Milton Civic Club, the Odd Fellows Lodge, the Masonic Lodge; served as a clerk of the school board for 25 years; and was an elder in the Friends Church. Surviving are his widow; a son, Dr. Ernest T. Pearson, also of West Milton; a daughter and a sister.

Frederick Clyde Potter, M. D., Cuyahoga Falls; Medico-Chirurgical College of Philadelphia, 1909; aged 67; died September 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Summit County Medical Society in 1929 and a delegate to the Ohio State Medical Association, 1931-37; diplomate of the American Board of Pathology; fellow of the American College of Physicians; member of the American Psychiatric Association and the American Society of Clinical Pathologists. Dr. Potter did pathological work at Akron hospitals for many years before going into private practice at Cuyahoga Falls about two years ago. He served in the Army Medical Corps during World War I and during World War II served with the rank of colonel. He was a member of several Masonic orders. Surviving are his widow and a brother.

Frank Vernon Riche, M.D., Dayton; Ohio State University College of Homeopathic Medicine, 1921; aged 52; died September 19; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Riche had practiced medicine in Dayton since the completion of his medical education. He was a member of several Masonic orders, the Isaac Walton Club, Dayton Canoe Club, Dayton Outdoor Club, National Rifle Association, the American Legion, Round Table International and the Presbyterian Church. Surviving are his widow and his mother.

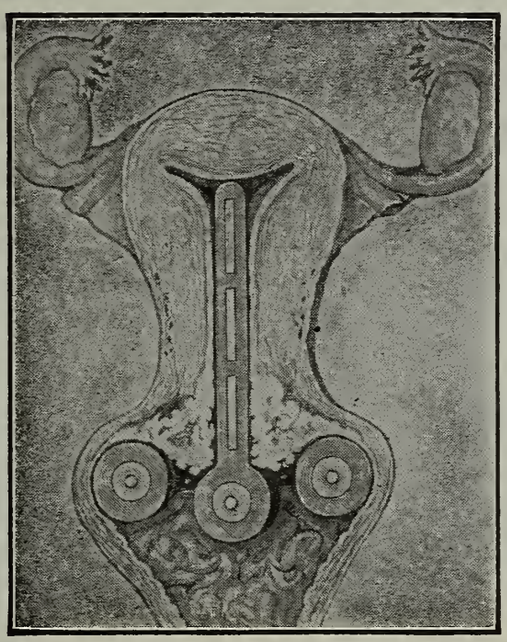
H. Paul H. Robinson, M.D., Medina; University of Pittsburgh School of Medicine, 1895; aged 77; died September 14; member of the Ohio State Medical Association and Fellow of the American Medical Association through 1948; vice-president of the Medina County Medical Society in 1931, president in 1937, and chairman of the legislative committee, 1935-36. Dr. Robinson, who had practiced since 1909 in Medina and vicinity, was also active in other phases of community life. He served on the local board of education, and was health commissioner for a number of years. He held memberships in several Masonic orders and the Congregational Church. A veteran of the Spanish-American War and World War I, he was a member of the American Legion. Surviving are his widow and three daughters.

William Francis Shannon, M.D., Detroit, Mich.; University of Cincinnati College of Medicine, 1938; aged 38; died September 13; former member of the Ohio State Medical Association through 1946 and of the American Medical Association. Surviving are his widow, three children, his parents and two sisters.

James K. Timanus, M.D., Fostoria; University of Maryland School of Medicine, 1949; reported missing September 17 in the Noronic disaster and presumed dead. Dr. Timanus after completing his medical education had moved his residence from Fostoria to Lakewood to begin his internship at St. Luke's Hospital. Mrs. Timanus reportedly died with her husband in the disaster. Surviving are two small children and his parents.

Accidents far outrank any of the more generally feared childhood diseases as a cause of death among children 1 to 14 years old, according to the National Safety Council's statistical yearbook. There were 10,731 accidental deaths in that age group in 1947, three times more than were claimed by pneumonia, the next more important cause of death. Accidents caused 42 times as many deaths as polio.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

CLINTON

Members of Fayette, Highland and Green county societies were guests at the Oct. 6 meeting of the Clinton County Medical Society in Wilmington. Speakers and their subjects were: Dr. Allan C. Barnes, Columbus, "Use of Hormone Therapy"; Dr. Robert F. Daly, Columbus, "Obstetric Accidents"; and Dr. C. H. Hendricks, "Diet in Pregnancy." The three speakers are of the Ohio State University College of Medicine, Columbus.

HAMILTON

Dr. Elmer L. Henderson, President-Elect and Chairman of the Board of Trustees of the American Medical Association, was guest speaker at the September 20 meeting of the Academy of Medicine of Cincinnati. His subject was, "How the A. M. A. Is Spending Your $25 Assessment."

At the Oct. 4 meeting, Dr. Leo G. Rigler, University of Minnesota Medical School, Minneapolis, spoke on "Early Diagnosis of Carcinoma of the Lung."

At the Oct. 18 meeting, Dr. J. R. Heller, director, National Cancer Institute, Bethesda, Md., spoke on "Progress in Cancer Research and Control." This was a joint meeting with the Cancer Council.

The scheduled program for November and December is as follows:

Nov. 8—Dr. Raymond W. Bieter, University of Minnesota Medical School, "Drugs Used for the Control of Pain."

Nov. 22—Dr. Thomas Francis, Jr., School of Public Health, University of Michigan, "Influenza —the Clinical Epidemiological and Public Health Sigificance of Multiple Immunological Types of the Virus."

Dec. 6—Dr. Harry Engle, National Institutes of Health, Bethesda, Md., "The Therapeutic and Prophylactic Use of Penicillin."

Dec. 20—Dr. James H. Sterner, associate medical director, Eastman Kodak Company, Rochester, N. Y., "The General Practitioner and Occupational Medicine."

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CHAMPAIGN

Dr. John Porterfield, Columbus, director of the Ohio Department of Health, explained the Department's vital statistics report at the Sept. 21 meeting of the Champaign County Medical Society in Urbana.

CLARK

Dr. Armand G. Sprecher, University of Pennsylvania College of Medicine, was guest speaker at the Oct. 17 meeting of the Clark County Medical Society held at the Ker-Deen Inn. His subject was "Therapeutic Approach to the Problem of Arthritis."

DARKE

Dr. Phillip T. Knies of Columbus spoke on the subject, "Diagnosis and Management of Acute Coronary Thrombosis" at the Oct. 18 meeting of the Darke County Medical Society in Greenville.

MIAMI

The regular meeting of the Miami County Medical Society was held on Oct. 7 at the Stouder Hospital, Troy. Speaker for the occasion was Dr. Jonathan Forman, Columbus, Editor of *The Ohio State Medical Journal* and professor of the history of medicine at Ohio State University and lecturer on allergy.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

ALLEN

Dr. Virgil S. Counseller, Rochester, Minn., addressed the Sept. 20 meeting of the Lima and Allen County Academy of Medicine on the subject, "Vesico-Vaginal Fistula and Its Surgical Management." The dinner meeting was held at the Shawnee Country Club in Lima.

At the Oct. 12 meeting of the Society, Dr. Perrin H. Long, Johns Hopkins University, spoke on "Recent Advances in Antibiotic Therapy."

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

CUYAHOGA

The Pediatrics Section of the Academy of Medicine of Cleveland was held on Oct. 5 with the following scientific program: "Tinea in Children," Dr. R. B. Hauver; "Thoracic Tumor in a Five Year Old Child," Dr. J. D. Pilcher; "Etamon in the Treatment of Poliomyelitis," Dr. R. M. Eiben; and "Encephalitis in Measles—a Review of the Recent Epidemic," Dr. M. L. Rohrer.

The Industrial Medicine and Orthopedic Section of the Academy was held on Oct. 12 with the following scientific program: "Industrial Medical Problems of the Body Building Industry," Dr. A. F. Lecklider, Detroit, medical director

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Fisher Body; "A Case of Generalized Emphysema of an Upper Extremity," Dr. Ernest Wolff and Dr. Henry H. Brown. The dinner meeting was held in the Fisher Body plant and was followed by a tour of the plant and plant hospital.

Experimental Medicine Section of the Academy and Section of the Society for Experimental Biology and Medicine met on October 14 with the following program: "Myocardial Intolerance to Excessive Blood Transfusion," by Drs. William D. Holden, Jack W. Cole, A. Frank Portmann; "Electrical Alternation in Experimental Coronary Artery Occlusion," by Drs. H. K. Hellerstein and I. M. Liebrow; "An Analysis of the Corrigan Pulse—A Clarification of Misconceptions," by Robert S. Alexander, Ph. D.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

COLUMBIANA

Dr. Robert M. Dunlap, Columbiana County health commissioner, explained immediate and long-term programs of the Columbiana County Public Health League at the Sept. 21 meeting of the Columbiana County Medical Society.

PORTAGE

Speaker at the Oct. 6 meeting of the Portage County Medical Society was Dr. Robert M. Bartlett, Akron, who discussed "Water and Salt Need of the Sick Patient." The meeting was held in the Robinson Memorial Hospital, Kent.

Eighth District

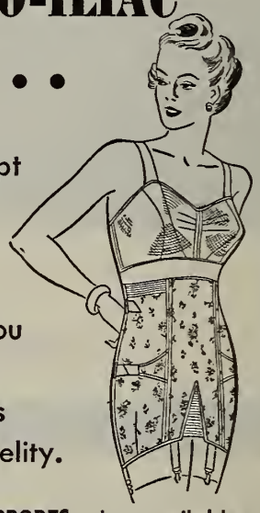
(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

The annual fall meeting of the Eighth Councilor District of the Ohio State Medical Association was held at the Cambridge State Hospital, Thursday afternoon, October 6, with approximately 50 physicians in attendance. Following a chicken dinner in the cafeteria, the business and scientific sessions were held in the hospital's assembly room.

Dr. Wm. L. Denny, Cambridge, welcomed the visiting physicians in behalf of the Guernsey County Medical Society, of which he is president. Brief talks on organization matters were given by Dr. Chester P. Swett, Eighth District Councilor, and George H. Saville, Columbus, Director of Public Relations, Ohio State Medical Association.

The scientific program was as follows: "The Diagnosis and Treatment of Carcinoma of the Large Intestines," Dr. Robert M. Zollinger, Columbus, professor of surgery, Ohio State University College of Medicine; "Early Treatment of Mental Disorders," Dr. Arthur T. Hopwood, Su-

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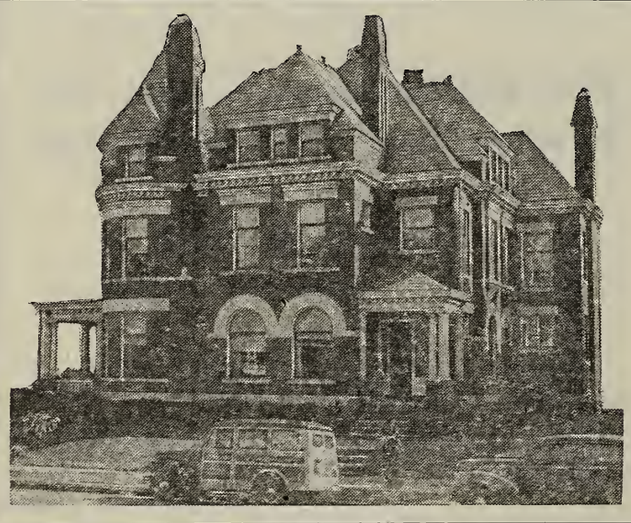
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perintendent, Cambridge State Hospital; "Common Dermatological Problems," Dr. F. Gordon Lawyer, Cambridge.

The meeting was arranged by the Eighth District officers: Dr. M. C. McCuskey, president, and Dr. Robert A. Ringer, secretary, both of Cambridge.

A meeting of the Eighth District Woman's Auxiliary was held concurrently with the conference.

FAIRFIELD

Dr. Wayne Baronaugh, Parkersburg, W. Va., spoke before the September meeting of the Fairfield County Medical Society, discussing fractures and illustrating points with apparatus. Two new members, Dr. Richard Reed and Dr. Fred Jones, were accepted.

The following officers elected by the society will take office in January: Dr. Wilford D. Nusbaum, to succeed Dr. H. M. Amstutz, as president; Dr. Victor N. Kistler, vice-president; Dr. Arthur B. Van Gundy, secretary-treasurer. Dr. L. E. Stenger was elected delegate and Dr. William M. Kuntz, alternate.

Dr. Chester P. Swett, Councilor of the Eighth District, Ohio State Medical Association, presented 50-year pins to Dr. W. R. Coleman and Dr. C. A. Barrow of Lancaster and Dr. A. V. Lerch of Pleasantville.

MUSKINGUM

The theme of the Oct. 12 meeting of the Muskingum County Academy of Medicine was "The Recognition and Treatment of Congenital Heart Disease." The subject was discussed from the standpoint of the pediatrician by Dr. O. W. Hosterman, from the standpoint of the radiologist by Dr. Joseph L. Morton and from the point of the chest surgeon by Dr. Karl P. Klassen, all of Columbus.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

SCIOTO

At the Oct. 10 meeting of the Hempstead Academy of Medicine, Dr. A. B. Oakes of Portsmouth spoke on the subject, "Sprains of the Ankle." A buffet luncheon was served at the Nurses' Reception Hall, General Hospital, Portsmouth.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FRANKLIN

The Columbus Academy of Medicine had as its guest speaker at the first fall meeting, Oct. 3, Dr. Merrill Sosman, Harvard University, who spoke on the subject of X-ray diagnosis of dis-

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eases of the chest. His was the 11th of a series of talks by outstanding physicians on the theme, "What's New in Medicine."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

"Convulsions and Encephalitis," was the topic of a discussion by Dr. John A. Toomey, Cleveland, at the Oct. 11 meeting of the Lorain County Medical Society.

RICHLAND

The Richland County Medical Society and the Active Staff of Mansfield General Hospital, held a combined meeting at the hospital on the evening of Sept. 29. Guest speaker was Dr. Donald M. Glover, Western Reserve University School of Medicine, Cleveland, who spoke on "Plastic Repair of Deformities Resulting from Injury."

Woman's Auxiliary . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee
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JEFFERSON

Speaking before the Woman's Auxiliary to the Jefferson County Medical Society, at its initial fall meeting on September 6, George Byrum, superintendent of the Ohio Valley Hospital, pointed out that the auxiliary could become a leader in a public relations program for the hospital. Mr. Byrum suggested that the members sponsor a social program for the student nurses in an effort "to encourage girls to enter nursing and to stay at the hospital." As another project, he suggested redecoration of the hospital staff room.

Mrs. Walter Cunningham, president, presided at the meeting. Acting as hostesses were Mrs. Albert Sunseri, social chairman, and Mrs. F. B. Harrington.

The group entertained district auxiliaries from Belmont and Tuscarawas Counties on October 4. (For details, see account of district meetings.) A dinner for the county medical society and a benefit bridge are planned for November.

KNOX

Mrs. N. M. Reiff, tenth district director, was guest speaker at the September meeting of the Knox County Auxiliary. She spoke on "Dangers of Socialized Medicine." The business session was conducted by Mrs. Raymond S. Lord, vice-president.

Mrs. Robert Hoecker and Mrs. C. E. Cassady presided at the refreshment table. Co-hostesses were Mrs. J. L. Baube and Mrs. Joseph Allman.

LIMA

The Woman's Auxiliary to the Lima and Allen County Medical Society held its September "covered dish" luncheon meeting at the home of Mrs. H. L. Stelzer. Twenty-nine members were present; three new members were welcomed into the auxiliary.

Following the luncheon, Mrs. Charles Leech gave a brief outline of this year's program. Mrs. Karl Ritter spoke on "The History of the American Medical Association—Its Aims, Activities, etc." Mrs. A. A. Dalton reported on the National Convention. Tentative plans were made for the October meeting to be held as an open meeting and Public Health Day, with Dr. Bernstein as guest speaker, presenting as his subject "Cancer."

MONTGOMERY

The Woman's Auxiliary to the Montgomery County Medical Society opened its fall season with a tea at the Dayton Art Institute. Seventy members attended.

The program featured a sound film on "New Frontiers of Medicine" as well as a speaker from the Chamber of Commerce who spoke on how that civic group is working to combat socialized medicine. Another speaker was Mr. Robert Freeman, executive secretary of the Montgomery



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County Medical Society, who explained parts of the National Health Insurance bills.

OTTAWA

The Ottawa County Auxiliary held its September meeting at the Willow Beach cottage of Dr. and Mrs. W. R. Gibson. It was announced that the free mobile X-ray unit would be in Ottawa county during October. Dr. and Mrs. George Boon of Oak Harbor will be hosts at the next meeting.

The Ottawa County group was hostess to the fourth district meeting (see account of district meetings).

RICHLAND

The Auxiliary to the Richland County Medical Society held a luncheon meeting at the Westbrook Country Club in September, with thirty-four members present. Mrs. Myron S. Reed and Mrs. P. O. Staker were hostesses. During the business meeting, plans were made for a rummage sale to be held in the near future.

The October meeting was a guest luncheon at the Mansfield-Leland Hotel, at which Mr. Hugh W. Brenneman, public relations counsel of the Michigan State Medical Society, told his listeners that "socialized medicine is but one step on the road to the welfare state." Mr. Brenneman spoke before a gathering of some 250 women's club officers and representatives. The Richland County Auxiliary served as hostess.

The public relations counsel was introduced to the meeting by Mrs. H. G. Knierim, vice-president and program chairman. Choosing as his subject, "It's No Bargain," Mr. Brenneman urged his audience to support the voluntary system of health insurance which he termed the "democratic way."

SCIOTO

The Woman's Auxiliary to the Hempstead Academy of Medicine began its 1949-1950 season September 14 with a luncheon meeting at the home of Mrs. H. M. Keil. Mrs. Keil served the luncheon buffet style on her lawn assisted by Mrs. C. L. Ferguson, Mrs. W. E. Scaggs, Mrs. H. A. Green, Mrs. A. P. Hunt and Mrs. Milton Levine.

The business meeting was presided over by Mrs. W. A. Ray, president. Following the business session, bridge and other contests provided the entertainment.

DISTRICT MEETINGS

(Editor's Note: These are just a few of the reports that have come through in time to make this issue of *The Journal.)*

FOURTH DISTRICT

The Fourth District meeting was held on September 13 at Port Clinton, with the Ottawa County Auxiliary as hostess. The Port Clinton

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United Brethren church was the scene of the luncheon meeting.

Dr. LeRoy Belt, president of the Ottawa County Medical Society, gave the address of welcome. Mr. Robert Reider, editor of the Ottawa County *Exponent* and representative to the Ohio Legislature, addressed the group on "Women in Politics." Mrs. C. W. Kirkland, state auxiliary president, urged her listeners to assist doctors in educating the public on the fallacies of socialized medicine. She presented Mrs. George Cooperrider, president-elect, who also addressed the group.

FIFTH DISTRICT

The Fifth District meeting was held on Wednesday, September 14, at the Lake Shore Hotel in Cleveland. There was a good representation of officers and committee chairmen from the three organized counties in that district.

Dr. Fred Dixon, Cleveland, Fifth District Councilor of the Ohio State Medical Association, gave an outline of what he felt the members of the auxiliaries should do. He urged the women to use their influence in supporting candidates favorable to the program of the American Medical Association, and to play a leading and decisive part in the public relations program of the Ohio State Medical Association.

Mrs. C. W. Kirkland, state president, and Mrs. George Cooperrider, president-elect, also gave stimulating talks.

SEVENTH DISTRICT

The growing need for qualified nurses and the problem of socialized medicine were the two topics featuring the Seventh District luncheon meeting held on October 4 at the Steubenville Country Club. The Jefferson County Auxiliary served as hostess.

The meeting was presided over by the Seventh District director, Mrs. Carl Goehring. Mrs. Walter Cunningham, president of the Jefferson County Auxiliary, welcomed the conference guests. Guest speakers included Mrs. C. W. Kirkland, state president; Mrs. George Cooperrider, state president-elect; Mrs. Paul Davis, state *Hygeia* chairman; Mrs. D. H. Downey, state chairman nurses' scholarship loan fund. Other officials attending were Mrs. R. H. McCommon, state corresponding secretary; Mrs. Peter Lancione, president of the Belmont County Auxiliary; Mrs. Carl Lincke, whose husband is president of the Ohio State Medical Association; Mrs. M. W. Everhard, president of the Tuscarawas County Auxiliary.

Mrs. Albert Sunseri was chairman of the conference luncheon. Conference program chairman was Mrs. Edward Weinman.

ELEVENTH DISTRICT

The eleventh district luncheon meeting, sponsored by the Erie County Auxiliary, was held on

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September 12 at the Plum Brook Country Club in Huron. Mrs. Paul N. Squire, vice-president, greeted the visiting district members and opened the meeting which was then turned over to Mrs. C. E. Swanbeck, Eleventh District director.

Mrs. Swanbeck introduced state auxiliary officers present at the meeting: Mrs. C. W. Kirkland, president; Mrs. George Cooperrider, president-elect; Mrs. C. H. Bell, recording secretary; and Mrs. Ross Knoble, radio and visual education chairman. Also in attendance was Mrs. J. L. Stevens, a past-president of the state auxiliary and its only honorary member.

Mrs. Kirkland was the afternoon's principal speaker. She concluded her talk on auxiliary activities with this pertinent quotation from Charles Hughes' *Doctor's Philosophy in Living*: "Fellowship in joy, not sympathy and sorrow, is what makes friends." Mrs. Cooperrider also addressed the group on the organization of county auxiliaries.

EXECUTIVE BOARD

The Executive Board meeting of the Woman's Auxiliary to the Ohio State Medical Association was held on Wednesday morning, October 19, at the Fort Hayes Hotel in Columbus. Following the Board meeting, there was a luncheon and conference with presidents and presidents-elect of the local county auxiliaries.

Dr. Carll S. Mundy, Toledo, Fourth District Councilor of the Ohio State Medical Association, and Mr. George H. Saville, public relations director for the Association, were the two guest speakers.

Complete Inventory of Registered Professional Nurses Available

A complete inventory of registered professional nurses in the U. S. A. and its territories is being released by the American Nurses' Association at the request of the National Security Resources Board according to Pearl McIver, president, American Nurses' Association, and Ruth Freeman, chief of the nursing section of the National Security Resources Board.

The inventory of nurses, which has been secured by the A. N. A. through cooperation with state nurse-licensing boards and state nurses' associations, provides data on the number and location, age, marital status, responsibility for dependents, whether the nurse is actively engaged in nursing and the field of employment and position, type of preparation and experience in special fields.

Paper bound copies are available from the American Nurses' Association, 1790 Broadway, New York 19, N. Y., at $1.00 per copy.

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A.M.A. Interim Session . . .

Full-Scale Scientific Program Scheduled Dec. 6-9 in Washington; Physicians Are Advised To Make Their Reservations in Advance

ADVANCE registrations and hotel reservations are now being received for the 1949 Clinical Session—the third annual mid-year meeting of the A. M. A.—to be held in Washington, D. C., December 6-9.

Attention to those details at this time will assure physicians a wide choice of hotel accommodations and will eliminate all delay in registering at the National Guard Armory upon arrival in Washington. Requests for reservations should be made before November 9 and sent to the Chairman of the Subcommittee on Hotels, American Medical Association, Hotel Reservation Bureau, Star Building, Washington 4, D. C.

The Clinical Session will provide a full-scale scientific program specifically designed for the general practitioner. Outstanding physicians will discuss such subjects as diabetes, pediatrics, laboratory diagnosis, physical medicine and rehabilitation, arthritis, dermatology, X-ray diagnosis, cancer, poliomyelitis and other topics.

PROGRAM ON PEDIATRICS

Typical of the complete coverage which will be given medicine in the fields in which the general practitioner is interested is the program covering pediatrics. In sessions beginning on the afternoon of December 6 and continuing through the morning of December 9, approximately 35 papers will be presented by leading specialists from all parts of the country.

In another section, about the same number of papers will deal with the problems of delivery alone. More than 20 physicians will present their findings and views on diabetes.

One of the features of the section dealing with arthritis will be a report on the present status of Cortisone and ACTH, two compounds which have opened new approaches to the treatment of rheumatoid arthritis.

SCIENTIFIC EXHIBITS

Coordinated with this outstanding scientific program will be approximately 100 scientific exhibits which will present original work on the subjects discussed.

The newest offerings of 125 manufacturing firms will comprise the Technical Exposition. Here will be found the latest developments in scientific medical research, drugs and equipment.

The clinical sessions and the exhibits will be held in the National Guard Armory, Capitol Avenue and East 19th Street. The exhibit hall will be open throughout the meeting, 8:30 a. m. to 6 p. m., giving ample opportunity to study the latest additions to modern medical practice.

TELEVISION

Televised surgical and clinical procedures, similar to those shown in color at the A. M. A. annual session in Atlantic City last June, will be presented at the Washington meeting. The demonstrations will originate in the Johns Hopkins Hospital and will be shown on screens in the armory. The television schedule will be spread over four days.

The House of Delegates will meet at the Hotel Statler during this session. One of the first orders of business will be the annual selection of the general practitioner who has made an exceptional service contribution to his community. A gold medal will go with the honor.

ENTERTAINMENT

An entertainment program for attending doctors and their wives is being developed. The highlight of this will be on Wednesday evening, December 7, when Philip Morris will originate its "This is Your Life" broadcast from the Hotel Statler. The radio program will be followed by a stage show in which outstanding stars will participate.

For the convenience of doctors making advance registrations and reservations, *The Journal of the American Medical Association* is publishing in its advertising section every week, convenient hotel reservation and advance registration blanks. Listed also are the leading hotels and their rates.



Ohio Public Health Officers Meet in Columbus

At a meeting held October 13 and 14 in Columbus members of the Ohio Federation of Public Health Officials approved constitutional changes in their organization to make it a section of the American Public Health Association. Under the new provisions, the organization will be known as the Ohio Public Health Association.

Membership in the organization, in the future, will be more general in scope, since qualifications require only that the member be "interested" in public health, rather than "engaged" in public health, as previously stated.

Speakers at the meeting included Dr. A. B. Price, Regional Medical Director, U. S. P. H. S., Cleveland, who spoke on "What About the Future of Public Health"; Dr. Joseph T. Noe, Medical Director, U. S. Potters Association in Columbiana County, "Industrial Medicine Looks at Public Health"; David Cox, a Chicago Public Relations Consultant, "Public Relations of a Local Health Department"; and Dr. Thomas Dublin, Medical Director, National Health Council, New York, who discussed "The Health Council and the Local Health Department."

During his address Dr. Dublin called attention to the booklet "Ohio Can Have Better Public Health," which was recently published by the Ohio Committee on Public Health, under the chairmanship of Charles S. Nelson, Executive Secretary of the Ohio State Medical Association. The speaker stated that it is "one of the really significant documents on public health at the present time." He urged that each member of the Association have five or ten copies on hand so that he may transfer the facts contained therein to other people.

Dr. Dublin stressed the need for teamwork among professional groups, the voluntary agencies, and the public, the groups, which in general make up a "health council."

Dr. Carl A. Wilzbach, Health Commissioner of Cincinnati, and Chairman of the Committee on Education of the Ohio State Medical Association, was named president-elect of the Association. Dr. F. E. Mahla, Health Commissioner of Lucas County, succeeded Dr. H. H. Pansing, Health Commissioner of Montgomery County, as president of the organization during the meeting. The organizational changes were effected during the administration of Dr. Pansing. Roy Haines, district sanitarian, Bellefontaine, was elected secretary, and Miss Anne Burnes, consultant nurse, Ohio Department of health, was named delegate to the American Public Health Association.

During the general session of the second day, the members of the association expressed their disapproval of compulsory health insurance, stating their belief that health needs can best

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GYNECOLOGY—Intensive Course, Two Weeks, starting February 20. Vaginal Approach to Pelvic Surgery, One Week, starting November 7, March 6.

OBSTETRICS—Intensive Course, Two Weeks, starting November 7, March 6.

PEDIATRICS—Intensive Course, Two Weeks, starting April 3.

MEDICINE—Intensive General Course, Two Weeks, starting April 3. Gastroscopy, Two Weeks, starting March 6.

DERMATOLOGY—Formal Course, Two Weeks, starting May 1. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic & Lecture Course First Monday of every month. Clinical Course Third Monday of every month. X-Ray Therapy every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

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be met by extension of public health activities. The text of the resolution is as follows:

WHEREAS, under a system of free enterprise, the American medical profession has established the world's highest standard of scientific performance, treatment, and research, thereby helping the United States to become the healthiest major nation in the world; and

WHEREAS, we feel that the health needs of the nation can best be met through a strengthened program of public health services, health education, and disease prevention; and

WHEREAS, the experience of all countries where government has assumed control of medical services has shown that there has been a gradual erosion of free enterprise and a progressive deterioration of medical standards and medical care to the detriment of the health of the people, NOW, THEREFORE,

BE IT RESOLVED, that the Ohio Public Health Association, an association composed of persons interested and actively engaged in Public Health and Preventive Medicine in the State of Ohio, advocate the extension of full time public health services to those areas not already having these services, and the further extension of voluntary health insurance plans.

THAT we do hereby go on record as being opposed to any form of compulsory health insurance, or any system of political medicine designed for national bureaucratic control;

THAT a copy of this resolution be forwarded to the President of the United States, to each Senator and Representative from the State of Ohio, and that said Senators and Representatives are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

Army Commissions 169 Civilian Medical Interns

Commissions as first lieutenants in the Army Medical Corps Reserve, have been given to 169 medical graduates who have been accepted for internship training in approved civilian hospitals, it was announced by Major General R. W. Bliss, Army Surgeon General. They have been sworn in and called to active duty, with full pay and allowances of their grade, and will remain in the civilian hospitals for the completion of their internship.

With this group the Army Medical Department inaugurates the second year of civilian intern training under its Graduate Professional Training Program. Additional rosters of selected candidates will be announced from time to time.

Under the provisions of the Civilian Intern Training Program, a medical school graduate who has been accepted for internship by a civilian hospital approved by the Council on Hospitals and Medical Education of the American Medical Association may apply for a commission as first lieutenant in the Medical Corps Reserve. If accepted, he is called to duty and assigned in a training status at the civilian hospital of his choice. On completion of his internship, he serves two years for each year of training he has received as a Reserve officer.

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Veterans Administration

Veterans who have completed or discontinued courses of GI Bill training, and who now wish to take additional education or training at Government expense, must first show Veterans Administration that their new course is not avocational or recreational, but is essential to their employment objective.

This provision is contained in a V. A. instruction based on V. A.'s legal authority to review and act on changes of course and to determine whether a course is pursued for avocational or recreational purposes.

The Independent Offices Appropriation Acts for 1949 and 1950—basis of V. A.'s legal authority—prohibit V. A. from spending any money for courses which the Administrator of Veterans Affairs determines to be avocational or recreational.

GI Bill training sought by a veteran after he has completed or discontinued a previous course the instruction explains, will be considered avocational or recreational—regardless of the nature of the training—unless the veteran submits complete justification that the course "is essential to his employment."

* * *

Veterans Administration has spent approximately $1,000,000 and established research units in 12 hospitals in developing its radioisotope program to date, the V. A.'s Department of Medicine and Surgery announced.

* * *

President Truman in October signed Public Law 339 liberalizing compensation benefits for veterans, their dependents and beneficiaries. The compensation increase in basic rates becomes effective December 1, 1949.

In addition, the new law will:

1. Provide additional compensation for veterans with dependents who are rated 50 per cent or more disabled.

2. Raise the rate on compensation for World War I veterans with "presumed" service-connected disabilities.

3. Establishes new progressive compensation ratings for veterans with arrested cases of tuberculosis.

4. Increase the death compensation to wartime widows with one or more children.

5. Liberalizing present rules barring payment of compensation for injury or disease incurred (not as a result of own wilful misconduct) while under military or civil confinement.

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Civilian Medical Officers Needed By Army in Japan

The Department of the Army is urgently in need of medical officers to serve in a civilian capacity with the occupation forces in Japan. Minimum acceptable qualification requirements are a degree in medicine plus five years of progressive professional experience which includes one year of rotating internship in an accredited hospital. Service on active duty with the Army, Navy, or Veterans Administration may be substituted for the required internship.

The salary for these positions is $6,235.20 per year, plus 10 per cent post differential with quarters provided at no cost to the employee. Individuals selected for appointment must agree to remain a minimum of two years. Dependents may join the employee in approximately eight to ten months after arrival.

Civil Service Commission Form 57 should be submitted to: Department of the Army, Civilian Personnel Division, 1660 E. Hyde Park Blvd., Chicago 15.

Expand Sanitary Engineering

The Federal security administrator recently announced the creation of a new division in the Bureau of State Services, Public Health Service, to be known as the Division of Engineering Resources.

Surgeon General Leonard A. Scheele said the Division of Engineering Resources will centralize planning and developing of current and proposed programs of the Public Health Service in the expanding field of sanitary engineering and environmental health.

At its recent annual meeting in Indianapolis, the Indiana State Medical Society celebrated its 100th Anniversary.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18, 1950, Cleveland.

American Medical Association, Annual Session San Francisco, Calif., June 26-30, 1950.

American Medical Association Interim Session, December 6-9, Washington, D. C.

International Congress of Surgeons, U. S. Chapter, 14th Annual Assembly and Convocation, Atlantic City, N. J., Nov. 7-12.

National Society for Crippled Children and Adults, Annual Convention, New York, November 7-9.

Radiological Society of North America, 35th Annual Meeting, Cleveland, Dec. 4-9.

Sixth Councilor District of Ohio State Medical Association, Annual Postgraduate Day, Youngstown, November 30.

Trumbull County Medical Society Post Graduate Day, Warren, November 16.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

The Compleat Pediatrician, by W. C. Davison, M.D. ($5.00. Sixth Edition. *Duke Universty, Durham, North Carolina)*, comes to us better than ever. Of previous editions we said, "Full of wisdom, easily accessible." None of us have the opportunity to assemble and classify and spread on the printed page what medical knowledge we have. Dr. Davison, himself a great teacher and scholar, has done just that with the universal fund of information that he has gathered in a lifetime of study and practice.

Headaches: What Causes Them and How To Get Relief, by Noah D. Fabricant, M.D. ($2.50. *Farrar, Straus and Company, New York City)*, is a medical book for laymen. Its author is well known for his ability to strip a mass of confusion down to a clean-cut practical outline that anyone can see and understand. This volume deals with the more common of all symptoms and for which there are hundreds of causes and thousands of remedies. The author has made use of even the most recent progress in his attempt to be of service to the victim of headaches. He has been most successful in his attempt to supplement sound medical advice and not to confer upon the reader a medical degree. The book can be heartily recommended to supplement your own sound advice to your patients.

America's Health: A Report to the Nation, by the National Health Assembly. ($4.50. *Harper & Brothers, New York City)*, is the official findings and recommendations of the Assembly on public health policy for the next decade. One cannot dismiss this as a piece of propaganda for Socialistic-State Medicine. Although it is that, it is more, for it does present facts, figures, and points of view with which we must all be familiar whether we believe in education and a Republic or compulsion and totalitarianism.

These Are Your Children, by Gladys Gardner Jenkins, M.D., Helen Shacter, Ph.D., and W.W. Bauer, M.D. ($3.50. *Scott, Foresman & Company, Chicago)*, tells how to guide them year by year. It is too bad that all young parents will not, for one reason or another, be able to read this book.

Advances in Internal Medicine, edited by William Dock and I. Snapper. ($8.50. Volume III, 1949. *Interscience Publishers, Inc., New York City)*, presents ten essays approximately each 50 pages in length: Use of BAL in metallic poisoning, hemolytic anemias; modifying factors in penicillin therapy; streptomycin; histoplasmosis; antithyroid compounds; enzymatic methods in diagnosis; plasma fractionation; acclimatization to heat; and modern drugs in neurology—all written by outstandng authorities.

Voluntary Medical Care Insurance in the United States, by Franz Goldmann, M.D. ($3.00. *Columbia University Press, New York City)*, attempts to overcome the lack of factual information on the part of the public about voluntary medical care insurance. In summary, it is pointed out what we have not always realized, that this type of insurance is *insurance in fact,* and so can only cover those who can and/or will pay the premiums, and can only give coverage on those sicknesses whose incidence is predictable. Like all insurance, its subscribers tend to slant the selection against the fund, in that favorable risks are always under the temptation to cancel and unfavorable risks to continue the policies. The author points out that these plans must be realized so that they will not be hung on hospitals but rather must provide for improvements in these institutions.

The Case Against Socialized Medicine, by Lawrence Sullivan ($1.50. *The Statesman Press, National Press Bldg., Washington, D.C.)*, is a history of the movement to establish compulsory medicine on the part of the Federal Government as taken from the sworn testimony of medical men before the U.S. Senate's Committee on Labor and Welfare. As such it should be in your library and on your waiting-room table. There are those who prefer and who are more impressed by the printed word when found in a bound volume.

Shearer's Manual of Human Dissection, edited by Charles E. Tobin, Ph.D. ($4.50. *The Blakiston Company, Philadelphia)*, has been brought out and developed to meet the problem of decreased time allotted to Gross Anatomy and the increased number of students in the modern medical school.

Synopsis of Hernia, by Alfred H. Iason ($6.50. *Grune & Stratton, New York City)*, has been done with "comprehensive brevity" and contains all the new material on the subject.

Pathology of the Nervous System, by J. Henry Biggart ($6.00. Second Edition. *Williams & Wilkins Company, Baltimore, Maryland)*, is a student's introduction to the subject. It shows the reader how to apply the principles which he has learned in his study of pathology on other organs to the lesions of the nervous system.

Neuropathology with Clinical, Anatomical and Technical Supplements, by Ben W. Lichenstein, M.D. ($9.50. *W. B. Saunders Company, Philadelphia, Pa.)*, is a textbook in keeping with the rapid developments in neurological surgery and the increasing interest in psychiatry.

Electrocardiographic Technique, by Kurt Schnitzer, M.D. ($3.50. *Grune & Stratton, New York City)*, is strictly a work on the making of the record—the only book we know of devoted entirely to this subject. Its language is simple. It should be of great help to physicians and their technicians.

Treatment in Proctology, by Robert Turell, M.D., with a chapter on psychosomatic problem by Louis Lewis, M.D. ($7.50. *Williams & Wilkins Company, Baltimore, Maryland)*, represents in a fine way the application to a special field of the newer information in the science of general medicine. More specialties should have more books like this one. "Minding one's own business" is not as safe for a specialist in medicine as it is for a state.

Handbook of Materia Medica, Toxicology and Pharmacology, by F. R. Davison ($8.50. Fourth Edition. *C. V. Mosby Company, St. Louis, Missouri)*, has been brought up to date with antibiotics, antihistaminics, rutin, B. A. L., antithyroid drugs, newer antimalarials "nitrogen mustard" and many others.

Food and Facts for the Diabetic, by Joseph H. Barach, M. D., ($4.00. *Oxford University Press, New York City)*, gives the patient the necessary information for the victim to take care of himself and so to outlive the non-diabetic.

The Value of Hormones in General Practice, by W. N. Kemp, ($3.00. *Burgess Publishing Company, Minneapolis, Minnesota)*, is a manual prepared by this famous Canadian authority to assist the general physician to use in fullest possible way the many pharmaceutical hormone preparations. A very handy work.

The Practice of Refraction, by Sir Stewart Duke-Elder ($6.25. Fifth Edition. *C. V. Mosby Company, St. Louis, Missouri)*, presents new knowledge about transient changes in refraction and aniseikonia, and much new material on modern methods of examination. Seven printings and five revisions recommend this book.

Ethics in Sex Conduct, by Clarence Leuba ($2.50. *Association Press, New York City)*, is a manual on youth, sex, and marriage by this professor of psychology at Antioch College, Yellow Springs, Ohio. It is designed to assist young people to develop standards for themselves in the sexual area, and to help older people to understand modern youth. The author believes that all these things must be settled before marriage. The premarital period is the time for acquiring the attitudes, knowledge, and skills upon which marital happiness so largely depends. "Unless marriage at an early age is made possible and safe," he says, "many young people become either sadly frustrated or else engulfed in undermining conventional morality."

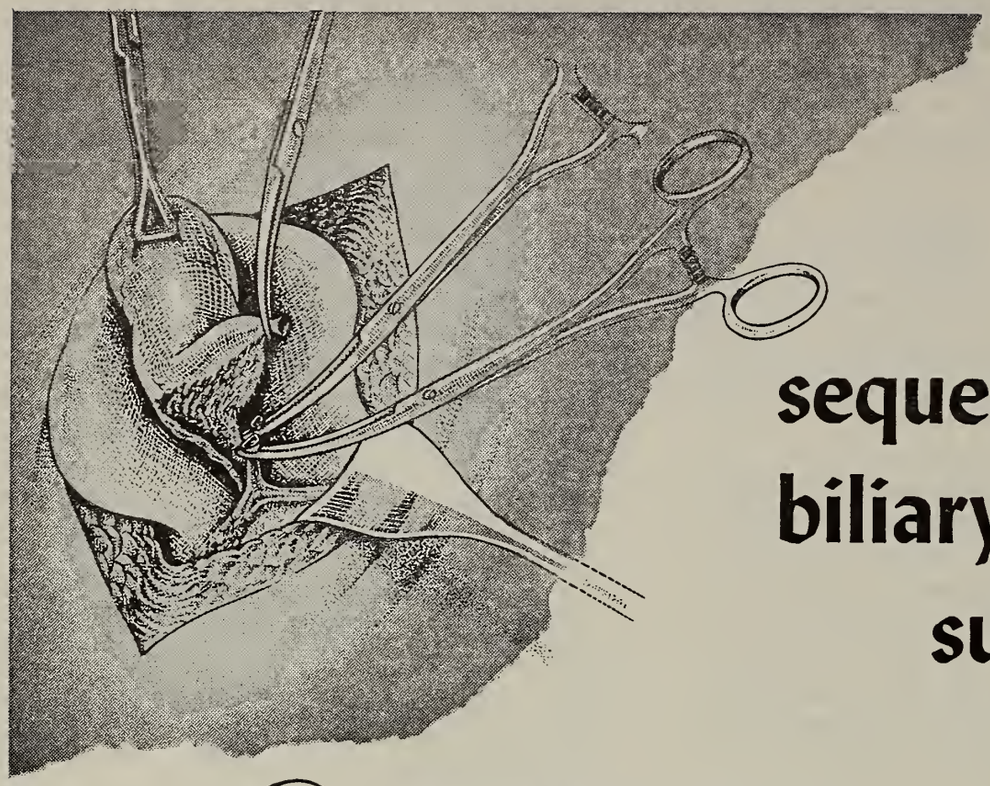
Diabetes and Its Treatment, by Joseph H. Barach, M.D. ($10.00. *Oxford University Press, New York City)*. Twenty-eight years ago insulin made its appearance on the medical scene. While it has immeasurably improved the result of our treatment of diabetes, it has not simplified to any great degree our knowledge of the disease. As the author, who was one of the first to use insulin during the period of its clinical trial, states in his preface: "The study of diabetes is broad and deep enough to absorb the capacities of the physician without cramping his point of view or narrowing his mental horizon. The author, nevertheless, insists that diabetes can be the most scientifically treated of all diseases. In diabetes there are considerably more than twenty controllable and measurable factors that can be manipulated and regulated by the understanding physician in the restoration of a patient toward normal metabolism and a normal state of health. Does this challenge you and make you want to read this book?

Guiding Human Misfits, by Alexander Adler, M. D., ($2.75. Second Edition. *Philosophical Library, Inc., New York City)*, is a practical application of individual psychology to the specific problem with a new chapter on post-traumatic neuroses in war and peace in view of experience in the last World's War.

Medicine of the Year (1949), edited by John B. Youmans, M.D. ($5.00. *J. B. Lippincott, Philadelphia)*, is the first issue of this year book in which 17 very distinguished authorities, such as Harry Alexander, editor of *The Journal of Allergy*, sum up in a concise statement of a page or two the trend of medicine in their particular field. All are very well done—brief but informative.

Early Carcinoma of the Uterine Cervix, by Hansjakob Wespi, M. D. ($6.50. *Grune and Stratton, Inc., New York)*, is an augmented and revised translation of this manual dealing with the general problem and the routine use of colposcopy in particular.

A Descriptive Atlas of Radiographs, An Aid to Modern Clinical Methods, by A. B. Bertwistle ($16.00. Seventh Revised Edition. *C. V. Mosby Company, St. Louis, Missouri)*, contains text connecting 980 illustrations covering every system of the body and showing the universal possibilities that the X-rays possess in diagnosis.



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The Interpretation and Treatment of Heart Failure During Anesthesia and Operations*

CARL J. WIGGERS, M. D.

IT is the purpose of this communication to present briefly certain basic information gathered from experimental work on animals which may afford clues for the interpretation of different types of acute heart failure incident to anesthesia and/or operations, and for the selection of appropriate measures of resuscitation.

THE FIRING AND ACTIVATION OF CARDIAC MUSCLE UNITS

Much as in an automobile engine, coordinated effective contractions of the ventricles are normally achieved by the firing of combustible material in millions of myocardial units. This requires both a spark and fuel. In the heart the spark is generated in the S-A node. Here a minute electric spike or action potential, more tersely called an impulse, is generated. As shown in Figure 1, this electric impulse is distributed radially over both atria and to the A-V node. After a brief delay it is transmitted across the border to the interior of the ventricles over a common A-V bundle and its two branches. From the endocardial surface of the ventricles the electric impulses pass through the ventricular septum and walls as indicated in the diagram. The distribution of these electric impulses gives rise to the well-known waves of the electrocardiogram.

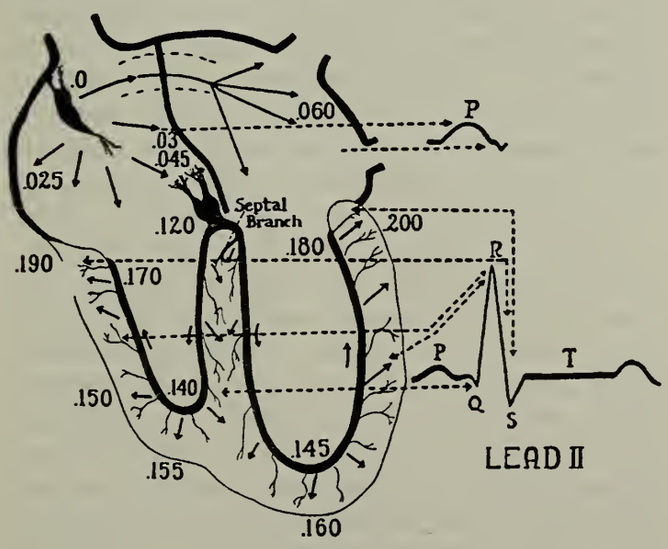


Figure 1

It should perhaps be emphasized that neither the distribution of the excitation waves nor the waves of the electrocardiogram have anything to do with the contraction processes in the chambers of the heart. Contraction of different chambers starts a brief interval after their excitation. As is shown schematically in Figure 2, atrial contraction begins approximately at the summit of the P wave and ventricular contraction at the apex of the R spike. Such contraction represents a release and conversion of energy from chemical to mechanical forms, much as motive power is developed from the ex-

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The Author

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plosion of gasoline in an automobile engine. Summarizing, the electrocardiogram gives evidence of the spread of the electric spark to myocardial cylinders and the contraction which follows represents the conversion of fuel into work.

FAILURE OF NATURAL PACEMAKERS: BRADYCARDIA, CARDIAC STANDSTILL, IRREGULARITIES, TACHYCARDIAS

Failure of the S-A node as a pacemaker can arise experimentally after intensive vagal stimulation and through the use of drugs which increase the concentration of acetylcholine or

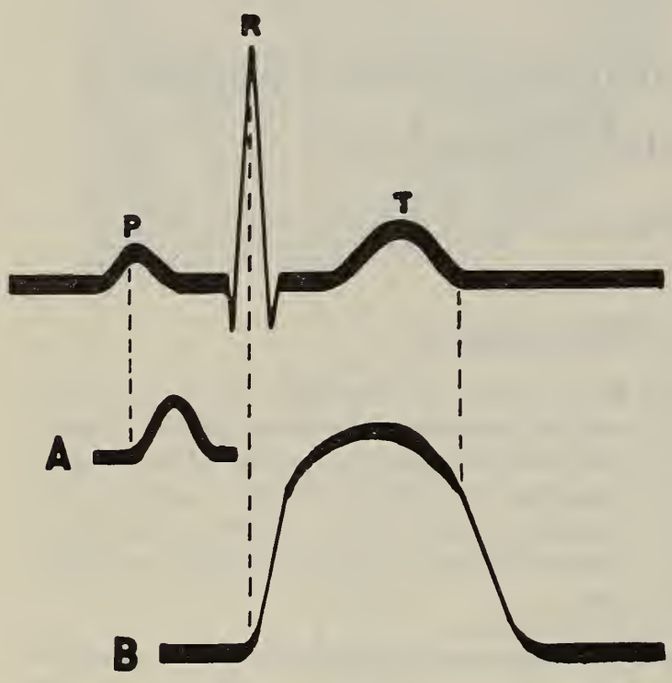


Figure 2

prevent its destruction by cholinesterase (eserine, pilocarpine, etc.). A similar suppression of S-A nodal activity has been reported clinically and develops occasionally during operative procedures. Recognition of such a type of standstill is important but easy. If the heart is exposed all the chambers are found to be quiescent. If the heart is not exposed complete failure of pacemakers is identified electrocardiographically by occurrence of a simple straight line. The most effective way to induce cardiac standstill of this type experimentally is through the intravenous injection of a proper dose of acetylcholine, mecholyl, or pilocarpine. In such instances the quiescent ventricles retain their excitability for some time. A mere touch suffices to produce a forceful beat. It is under such circumstances that periodic application of brief electric shocks restores a normal beat and may tide over the heart until the effects of the depressing drugs have worn off.

Although temporary cessation of the heart beat can be induced experimentally by vagal stimulation, it is difficult to produce a permanent standstill in this way, because lower centers in the A-V node and bundle branches become active and restore a slow but effective rhythm. This is the so-called "vagal escape." However, experimental work has shown that permanent stoppage of the heart beat may be caused through excessive vagus action, e. g., during final stages of anoxemic anoxia, during experimental cerebral anemia, through ligation of cerebral vessels, and in terminal stages of prolonged hypotension such as follow large hemorrhages, trauma, etc. Occasionally a similar vagal asystole occurs during surgical operations on animals for reasons as yet unexplained. For example, Ivy[1] has recently noted its occasional occurrence after transthoracic vagotomy for relief of peptic ulcer. A neurogenic form of pacemaker failure must therefore be recognized as a possibility during surgical operations in man. It has also been found experimentally that a permanent vagal standstill may be produced when subsidiary centers are excessively depressed by anesthetics. Under such conditions these centers develop too slow a heart rhythm to maintain an adequate arterial pressure and coronary flow, with the result that permanent standstill eventuates.

After the heart has been completely arrested for about one minute the vigour of contractions induced by artificial stimulation is greatly reduced, and in less than five minutes the response may fail entirely. The tissues have lost their excitability to all forms of stimuli, natural or artificial. It is of importance to recognize the early development of such an inexcitable state, for it limits the time during which artificial pacemakers can be expected to induce contractions. Such loss of excitability is not irreversible for a considerable time; it can be restored by pumping aerated blood through the coronary circulation by cardiac massage. This requires artificial respiration in order to insure the arrival of aerated blood to the left heart. But it may be stressed that supernormal inflation of the lungs must be guarded against when an artificial respirator is used, for creation of high positive alveolar pressures hinders the passage of blood through the pulmonary circuit. For performance of cardiac massage the manual method remains the best known procedure. Cardiac massage does not consist of an aimless squeezing of heart muscle; it must be performed with the objective of forcing a significant stroke volume into the aorta and through the coronary vessels. In order to allow adequate time for filling of the ventricles between compressions, the rate of compression should not exceed approximately 40 per minute. In order to empty the ventricles completely the force applied by the hand should be transmitted from apex toward base. In order to insure passage of a large fraction of the blood into the coronary

vessels, it is desirable occasionally to compress the aortic arch between the fingers. In normal anesthetized dogs such a procedure carried out effectively for 30 seconds to 2 minutes revives the excitability of a myocardium which has been stopped several minutes. Artificial stimuli become effective again and occasionally the natural pacemakers even revive.

Permanent standstill of the heart may also result from complete A-V block when subsidiary centers (A-V node, bundle branches) are depressed and cannot generate substitute rhythms. This is recognized by observing the presence of regular beats in the atrium of the exposed heart or by electro-cardiographic evidence that only P waves without succeeding Q-R-S-T complexes are recorded. In such instances revival of subsidiary centers can often be effected by therapeutic agents which raise their excitability. Since no general circulation exists during ventricular standstill, the hypodermic or intravenous administration of drugs is of course useless. They must be injected with saline intra-arterially so that they reach the coronary vessels, or alternately they may be administered by direct injection into the ventricular cavities. For these purposes, epinephrine or a 5 per cent solution of calcium chloride are useful agents. Barium chloride which has also been used appears somewhat less advisable on physiological grounds owing to its intense constricting action on arterioles, including those of the coronary system.

The development of acute auricular fibrillation, although not immediately perilous, may nevertheless cause serious embarrassment during operations. This is a state in which the A-V node is bombarded by myriads of impulses. However, only a reasonable number are permitted to pass at irregular intervals to the bundle branches and ventricles. As a consequence the ventricles contract rapidly and irregularly with beats of varying force. Indeed, many beats eject no blood into the aorta. The net result is a decline in cardiac output and arterial pressure, the latter reaching low fluctuating levels. Pulmonary and venous congestion supervene. This condition may be treated by the well-known blocking effect of digitalis preparations which reduces the number of impulses transmitted to the ventricles and thus induces fewer frustrate contractions and a greater number of vigorous contractions. Emergency use of rapidly active principles such as ouabaine would seem serviceable in the treatment of acute fibrillation.

Alternately, efforts may be made to abrogate the auricular fibrillation. Experimental work suggests the trial of several methods which have proved successful in dogs, viz., stimulation of vagus nerves, cooling the atria by bathing them with saline solution near zero degree centigrade, or by decreasing the refractory period of atrial muscle through the use of quinidine.

ABNORMALITIES IN ORDER OF EXCITATION

A skeletal muscle contracts best when two conditions are fulfilled: (1) that all muscle fibers are excited simultaneously, and (2) that one end of the muscle is fixed and the other allowed to shorten. The natural mode of ventricular excitation over the A-V bundle and its branches assures both of these conditions in the normal heart. The ventricular muscle walls are excited nearly simultaneously but the septum is excited a little in advance. This assures a rigid fulcrum around which contraction of the external walls can virtually wring blood out of the ventricular cavities.

When a block of one bundle branch occurs, excitation of the septum and ventricle of an opposite side is still normal, but excitation of the ventricular walls is delayed. Premature ventricular systoles or ventricular tachycardias operate in a similar way, but in addition preexcitation of the septum fails to occur (Figure 3-A). As a result of the progressive recruitment of contracting fractions and loss of a rigid septal fulcrum, the contraction of the ventricle proceeds more slowly, is not as vigorous and lasts for a shorter time, as shown by the dashed curve in Figure 3-B. When the two ventricles contract with unequal force the balance

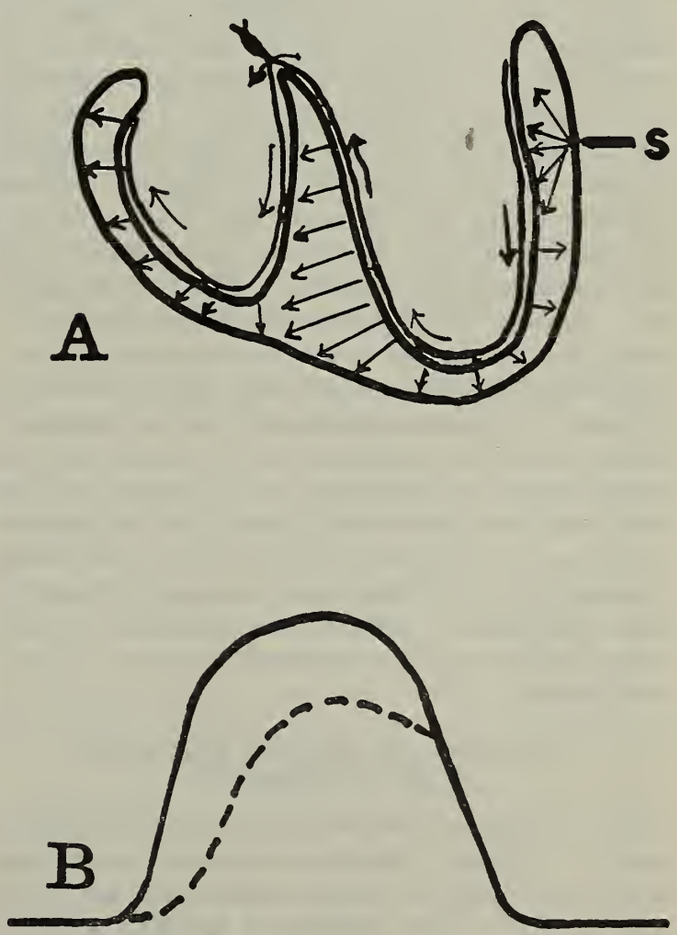


Figure 3

of the circulation is upset. For example, in left ventricular bundle branch block or left ventricular tachycardia the output of the right heart exceeds that of the left. As a result pulmonary congestion, right-sided stagnation, and a decline of arterial pressure follow. Repeated premature ventricular systoles during operative procedures are sufficient to upset the circulatory balance. Even a single premature systole can cause sufficient unbalance of the circulation so that three or four succeeding beats are required to restore equilibrium.

The ease with which premature contractions are induced by stimuli to the epicardial surfaces varies considerably in different hearts and is affected by different types of anesthetics. The threshold for mechanical stimulation is definitely enhanced by chloralose, an anesthetic favored by many in laboratory experiments. A basic study of the relative changes in myocardial excitability resulting from use of various anesthetics might well be projected for the purpose of selecting the one most suitable for operations on the heart. However, the surgeon required to operate on the heart has at his disposal a number of agents which raise the threshold of stimulation. Swabbing the surface of the heart with solutions of potassium salts or procaine are effective in this respect. However, attention may be called to the fact that effective doses of these drugs which abolish surface excitability completely induce changes in the S-T segment and T wave of the electrocardiogram. These are not indicative of serious myocardial damage. Their occurrence may, however, be confusing if electrocardiograms are taken during the course of operations. Overenthusiasm in the use of such agents must be curbed, for concentrated doses can be absorbed from epicardial surfaces and produce serious disturbances of excitation and contraction. It has long been known that potassium so applied can produce various arrhythmias by percolating through the myocardium and even lead to ventricular fibrillation. Intravenous injection of procaine induces significant disturbances in cardiac conduction.[2]

FAILURE IN CONTRACTILE RESPONSES OF THE MYOCARDIUM

The functional capacity of the myocardium may be reduced despite an orderly excitation when the contractile responses of individual fibers are impaired. The quality of gasoline and its rate of supply to a carburetor determine the efficiency of explosion induced by a spark in an automobile engine. Similarly, the availability of explosive material in muscle cells (high energy-organic phosphates, glycogen, etc.) and their rate of regeneration during diastole determine the effectiveness of contractions realized. Both of these processes depend on the efficiency of the coronary circulation, for thus oxygen is supplied for restitution processes and deleterious waste products are washed away. Restitution is also conditioned by humoral and nervous factors which regulate the explosive reactions leading to contraction. Time permits consideration of only a number of factors which may depress or annul contraction during anesthesia and operations.

ANESTHESIA

All known anesthetics exert some depressant effect on metabolic processes of the heart. However, a sufficient number are known which have no material effect. Volatile anesthetics in addition induce reflex, central nervous, and psychic reactions. Their effects on myocardial response have not been shown to be serious, except in the case of a few, such as chloroform and cyclopropane, which cause serious arrhythmias through central nervous actions and may even lead to ventricular fibrillation.

REDUCTION IN BLOOD VOLUME

Despite continued improvements in control of hemostasis, significant loss of blood still cannot be avoided in many types of operations. In such states, hemorrhagic hypotension develops mechanically through reduction in venous return and cardiac output. If a serious degree of hypotension is allowed to persist for thirty minutes or more, a state of impending shock characterized by pooling of blood in capillaries of all organs, supervenes. If allowed to continue for several hours, a state of shock develops which cannot be reversed by large or repeated transfusions of blood or blood substitutes.

Recent studies in our laboratory[3] have shown that myocardial depression contributes to the failure of the circulation in such conditions. The trend of events appears to be as follows: A state of hemorrhagic hypotension reduces the pressure head driving blood through the coronary circuit. Dilatation of coronary vessels to a maximal degree compensates partly but not entirely. Incidentally, anoxia is one of the most powerful coronary dilators known,[4] so that no additional benefit may be expected from the use of drugs reputed to have a coronary dilator action. The only effective method for improving coronary blood flow in hypotensive states is through an elevation of arterial pressure; but it is not immaterial how elevation of arterial pressure is produced. Experimental work has clearly indicated the inefficacy of epinephrine and allied pressor amines, probably because they accelerate the exhaustion of combustible material in the myocardium. Use of posterior pituitary extracts are even worse, for they cause the most powerful constriction of coronary vessels known and in consequence aid myocardial depression. Intra-arterial transfusion is the most

promising procedure for increasing coronary flow. Its practicability and value in preventing irreversible shock has recently been demonstrated experimentally by Glasser and Page.[5]

CORONARY OCCLUSION

Anesthesia and surgical procedures appear to enhance any natural tendency for coronary thrombosis. It is a problem that must probably receive greater attention from surgeons. The use of electro-cardiographic controls during operations will probably be stimulated by the advent of numerous types of direct writing electrocardiographs. The anesthetist or cardiologist should appreciate that some of these instruments may not be adequate for the detection of minor changes likely to follow acute coronary occlusion; also, that the effects of coronary occlusion are not always mirrored immediately in electrocardiograms recorded by our best instruments.

Even when disturbances of rhythm do not take place, coronary occlusion acts detrimentally upon the ventricle through the deletion of a part of the contracting fractions and a transfer of the burden to the fractions of normal myocardium. The dynamic effects on the circulation depend largely on the condition of the uninvolved muscle. If this be good, they react at once through well-established physiological laws by contracting more vigorously. In this way a normal cardiac output may be maintained. If, however, they are unable to respond as normal heart muscle, the output of the ventricle concerned is decreased. If this be the left ventricle, arterial pressure falls and pulse pressure becomes smaller; blood backs up into the pulmonary circuit and right heart which is thereby placed under a greater strain.

The value of oxygen in limiting the infarction or improving the contraction of uninvolved myocardium also appears of questionable value. As already pointed out, anoxia constitutes the most powerful coronary dilator known. Assuming that the oxygen tension of blood reaching the edges of a potential infarct would be increased, this could act only to reduce an existing coronary dilatation and thus would probably decrease the actual delivery of oxygen.

VENTRICULAR FIBRILLATION

Ventricular fibrillation was first described by the physiologist Ludwig, in 1849. It is an incoordinate type of contraction which produces no useful beats, despite a high metabolic rate of the myocardium. The condition may be compared to the action of an automobile engine in which the gas mixture in each of eight or more cylinders are exploded very frequently but entirely at random. Such an engine, like the fibrillating ventricles with their millions of tiny muscle cylinders all firing out of phase, would consume more fuel but produce no useful work. In the case of the ventricles, this means that no blood is expelled, that arterial pressure falls promptly to very low levels, and that death follows in six to ten minutes owing to anoxemia of the brain.

Sudden occlusion of coronary vessels (usually thrombosis) and electrocution, accidental or purposeful, are probably the two most common causes of human ventricular fibrillation. It may, however, be a cause of sudden death following inhalation of chloroform, benzol, cyclopropane, and other vapors. It may prove to be more often than we believe the cause of sudden death after (a) severe blows upon or trauma of the chest with or without obvious injury to the heart, and (b) in cases of stab, arrow, or bullet wounds in which death is not the result of hemorrhage and cardiac tamponade. The possibility that mechanical stimuli such as pricks of the ventricle with a surgical or hyodermic needle may eventuate in ventricular fibrillation in normal hearts was forced upon us during experiments carried out in 1912. In these experiments it was necessary to stab a ventricle with a cannula of an optical manometer or with an instrument for producing valvular lesions. In such experiments one becomes impressed with the great resistance of the heart to injury or severe manipulation. However, far too often, a quick stab, a slight adjustment of a trocar, or an apparently trifling insult resulted in unexpected fibrillation. This occurred in the hearts of young and old dogs alike, in hearts in good as well as poor dynamic and nutritive states.

A clue as to the cause of fibrillation produced in this way began to appear in 1925 during an investigation of the reaction of the ventricles to surface stimuli. In our zeal to ascertain the earliest moments of responsiveness of the dog's ventricles, very strong induction shocks were sometimes used. It was found to our disappointment, as far as the studies then in progress were concerned, that fibrillation was often induced by a strong induction shock. This was soon confirmed by others. Wegria and I[6] demonstrated unequivocally that the application of short condensor shocks localized to one spot on the ventricle, induces fibrillation only when such shocks fall during a short interval of late systole, never when applied during any other phase of the heart cycle. We, therefore, designated this the "vulnerable phase" of systole. A sharp needle stab delivered during this short interval of the heart cycle also resulted in fibrillation. It appears that an electric shock or an injury creates a highly polarized zone of tissue which becomes a focus for release of repetitive impulses at a higher rate than can be conducted away through cardiac tissue.[7] Thereby they start zigzag reentrant circuits which are

the basis of ventricular fibrillation. The statistical chance that a puncture of the heart with a hypodermic needle or other instrument, or the application of a stitch through the myocardium is likely to fall during this brief phase of the heart cycle, is admittedly small. However, it could happen to surgeons operating on the heart as it did to us in experimental studies that all of the statistical chances seem to pile up in successive operations.

We have tried to lessen the statistical chance of producing a mechanical stimulation during this period by making an effort to apply instruments or stitches only during the period of diastole. The application of procaine is said to reduce the likelihood of such reactions. It is difficult to be certain that such measures do not operate chiefly to create psychological reassurance of the surgeon rather than any real protection of the myocardium against fibrillation.

RESUSCITATION FROM VENTRICULAR FIBRILLATION

Our early attempts to abrogate fibrillation were not motivated by hopes that the method might ever prove useful in man; it was our immediate concern to conserve animals. It soon became obvious that our chance of defibrillating the dog's ventricles by trial and error methods was small, that it was necessary rather to establish the determinants of success or failure. After six years of study (1928-1931; 1939-1942) we were able to state the conditions under which successful abrogation of fibrillation and resumption of a normal beat might be expected,[8] and based upon them a series of procedures that have now proved valuable in human cases by Dr. Beck and his associates.[9] However, I consider it more important to stress the strategy of resuscitation rather than the details of technique.

The four basic requirements for successful revival may be succinctly summarized as follows: (1) Fibrillation must cease completely in every fraction of the myocardium. If even a vestige of fibrillating muscle remains, coordinate contractions never develop. (2) Adequate pacemakers must survive in order to initiate impulses with an excitatory value sufficient to inaugurate coordinated contractions. (3) Not too many pacemakers—preferably only one—should dominate the re-excitation of the defibrillated ventricle, for if too many act they cause a reversion to fibrillation. (4) The muscle fractions which are excited must be capable of responding with reasonably vigorous contractions, otherwise weak, coordinated beats result, and the heart dies in a hypodynamic state or reverts to fibrillation.

A proper procedure for abolition of all traces of fibrillation is of paramount importance. From time to time claims are made that this can be achieved in dogs by chemical agents or drugs injected into the ventricular cavities, followed by massage to the heart, or administered intra-arterially and thus forced through the coronary circulation. We have had no success with any of the agents so far suggested. A few abolish fibrillation, but at the same time depress rhythmic centers and thereby annul the pacemakers required for resumption of a coordinated beat.

In 1933, Hooker and Kouwenhoven[10] made a significant advance in showing that a strong alternating current, not more than 5 seconds in duration, abolishes fibrillation without affecting the pacemakers, and thus restores normal beats. These investigators were not pioneers in the use of the method of countershock but, as is often true in science, the greater credit belongs to those who place a discovery on a substantial foundation and give it currency in scientific thought or practice. These investigators also showed that fibrillation of the heart in the closed chest can likewise be abolished by sending a strong countershock through the heart by electrodes applied to the chest. This was subsequently confirmed by Williams and his associates at Columbia in rams which are more nearly comparable in weight to man.

Unfortunately, the method had its limitations which were clearly recognized by its discoverers. Revival rarely occurred when the ventricles had fibrillated more than two minutes. We discovered that the fibrillation which follows coronary occlusion is not affected even within this short span of time. In order to be practical, even for experimental purposes, it was necessary to extend the period of revival. This we feel constituted our contribution to the problem.[8] The change in technique which made this possible was slight, but the physiological strategy involved was a broad one and was suggested by entirely unrelated experiments.

In the first place, we had observed that failure to revive the ventricles after two or more minutes of fibrillation was generally not due to difficulty in abolishing fibrillation, but rather to the weak character of the coordinated contractions which followed. Secondly, the discovery was made during our study of coronary occlusion that the area affected by ligation of the coronary branch rapidly loses its power of effective contraction. Thus the idea began to dawn that the two-minute limit for revival after fibrillation is due to interruption of coronary blood flow, while the metabolism is even higher than normal. Vigorous contractions cannot occur in the absence of a supply of oxygenated blood. This led to precedence of the countershock by effective massage of the ventricles as described above. Such massage in addition to supplying the coronary vessels, causes a material elevation of blood pressure and forces blood through the vessels of the brain as well, extending their

period of viability. The improvement of the heart is shown by more vigorous fibrillating movements. Only when these become exceedingly vigorous should the countershock be applied by padded electrodes. I have personally witnessed over 1,000 revivals in all kinds of fibrillation in dogs weighing up to 18 kilograms through use of this method.

However, the method occasionally fails because it is not always possible to defibrillate thoroughly deep-seated regions such as the interventricular septum. If the hearts are large or the electrodes are not properly placed, an effective current may fail to pass through protected deep internal structures such as the interventricular septum. Various expedients have been tried to overcome such a contingency. We have increased the size of electrodes and the intensity of the countershock current used without great success. Moreover, very strong currents often spread to the auricles and start their fibrillation, an undesirable feature when the ventricles do revive. Beck and Mautz,[9] who have adopted our modification of the countershock method, found that injections of small doses of procaine into the ventricular cavity previous to the use of massage and countershock was apparently helpful in abolishing such residual areas of fibrillation. We have similarly attempted to aid the blocking action of electric currents by use of KCl solutions. Unfortunately, these drugs depress muscular contractions and unless cautiously used prevent the resumption of vigorous beats. For this reason we have questioned their value as an adjuvant to countershock.

Wegria and I utilized a rapidly repeated series of A-C shocks. In this way the fibrillation becomes progressively coarser, i. e., larger and fewer fibrillating areas are formed. The longer circuits created may then be completely interrupted and the fibrillation stopped without the necessity of having the countershock current traverse the entire myocardium. We called the process serial defibrillation. Its advantages are (1) since it acts by merging excitation rings an effective current does not need to traverse every fibrillating fraction. (2) The ventricular septum which is difficult to reach is defibrillated. (3) Weaker currents which are not so apt to start auricular fibrillation and have no aftereffect on the ventricles may be used. (4) The certainty of recovery seemed to be increased.

Finally, some of the difficulties which stand in the way of practical utilization of the countershock method in human cardiac fibrillation may be summarized: (1) It is exceedingly doubtful whether 110 volts A-C house current, generally available, can yield sufficient current to defibrillate larger human hearts when electrodes are applied to the chest wall. In rams, somewhat comparable in size, Williams and his associates found it necessary to use 3,000 volts, giving currents of 25 to 30 amperes, in order to achieve defibrillation through electrodes applied to the chest. The danger to the patient, not to mention their general availability, is apparent. (2) Any method of countershock employed without cardiac massage must not be expected to be effective beyond two minutes of fibrillation, and perhaps less. (3) For the present, our greatest hope for revival is apparently restricted to patients who develop fibrillation on the operating table, or are already in the operating room. Here prompt exposure of the heart, institution of artificial respiration, utilization of cardiac massage, and serial countershocks should prove effective. To meet such emergencies, cardiac surgeons generally will probably soon follow the lead of Dr. Beck in adding appropriate countershock apparatus as standard equipment for the operating room.

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Emphysema in Anthracosilicosis

Pulmonary emphysema in anthracosilicosis usually develops as a compensatory mechanism and later becomes a complicating disturbance of the pulmonary fibrosis. It occurs in the form of localized, lobular or widespread dilatations of the lungs, usually in the midst of fibrotic processes and conglomerate nodulation.

The causes of emphysema include malposition of thoracic structures, bronchitis, superimposed infection, bouts of severe paroxysmal cough, allergy and the degenerative processes of aging tissue related to vascular sclerosis.—Burgess Gordon, M. D., W. Va. Med. Jour., Vol. 45, No. 11, Nov., 1949.

Complete Heart Block in a Case of Acute Bacterial Endocarditis with Report of Autopsy Findings

ALAN L. FRANKEL, M.D.

COMPLETE heart block due to one of any number of causes is not rare. Unusual cases have been reported as being due to hemochromatosis,[1] tuberculosis,[2,3] German measles,[4] and diphtheria.[5] Heninger and Dickens reported a case showing calcareous deposits in the bundle of His which were responsible for complete heart block in a 62-year-old male.[6] Although acute bacterial endocarditis is by no means an uncommon entity, as a cause prima facie of complete heart block it is almost unheard of. Cardiac irregularities other than complete block are a frequent accompaniment of acute bacterial endocarditis. Involvement of the aortic valve is seen most often in these cases particularly where there is a disturbance of the auriculo-ventricular conduction time manifest in the P-R interval. As Segal said, ". . . frequency of the aortic involvement in the heart block group would appear to be in keeping with the observations of Tawara who pointed out the close relationship of the bundle of His to the anterior and right posterior aortic cusps."[7] Ninety-four electrocardiograms taken in 19 proven cases of acute bacterial endocarditis revealed a partial heart block in one, terminal auricular fibrillation in one, premature beats in three, and an unclassified arrythmia in three.[7]

The author wishes to present a case of complete heart block due to acute bacterial endocarditis which had ruptured through the upper portion of inter-ventricular septum disrupting the conduction system.

CASE REPORT

H. B., an 82-year-old Negro, was admitted to the Urology Service of St. Francis Hospital on August 25, 1948. An accurate and reliable history was not obtainable from the patient because of marked mental deterioration. He did say, however, that he had felt well except for frequency and dribbling, but denied ever having had complete urinary retention. Physical examination revealed a fairly well-developed, poorly nourished Negro, who was dyspneic and orthopneic and who appeared to be in acute distress. The pulse rate was 36/minute and regular. Blood pressure was 160/60; respirations were 20/minute. The skin was cool, moist, and tissue turgor was poor. There was bilateral arcus senilis and bilateral corneal opacities. There was a moderate amount of mucopurulent discharge from the right eye. There were moist crepitant late inspiratory and expiratory rales at the right base and there were scattered fine rales throughout the left upper lobe. The heart rate was 36/minute. The rhythm was regular, with frequently recurring extra-systoles suggestive of bigemini. The heart sounds were distant. There was slight cardiac enlargement to the left beyond the left mid-clavicular line and the point of maximum impulse was in the 5th interspace within the left mid-clavicular line. There was a grade V soft, blowing, high-pitched systolic murmur heard best at the mitral and aortic areas. There were no abdominal masses or soft organs palpable. There were enlarged, firm, discrete, non-tender inguinal lymph nodes. The peripheral vessels were greatly thickened and tortuous, but the femoral arteries were readily palpated. The dorsalis pedis and posterior tibial pulsations were not felt. Rectal examination revealed a moderate enlargement of the prostate and the gland was firm, slightly nodular, and non-tender. There was complete phimosis. Electrocardiogram revealed the ventricular rate to be 40/minute with an auricular rate of 100/minute. There were no P-R intervals indicating a complete auriculo-ventricular dissociation. Ventricular extrasystoles occurred regularly following each ventricular contraction. The diagnosis was complete heart block with bigemini. Flat plate of the abdomen revealed multiple radio-opaque shadows in the region of the prostate. Kahn and Eagle were negative, BUN 32 mgm. per cent, sugar 131 mgm. per cent, CO_2 combining power 49 vols. per cent, and prothrombin 50 per cent of normal. There were 4.31 million red cells with 12 gms. of hemoglobin; 16,400 white blood cells with 92 per cent neutrophils. The urine was packed with red blood cells. The clinical impression was: (1) Arteriosclerotic heart disease with mild congestive failure and complete heart block; (2) senile deterioration; (3) phimosis, complete; (4) benign prostatic hypertrophy. On the second hospital day the patient was circumcised to relieve the phimosis. He withstood the procedure well and urinary continuity was restored. However, the patient developed periodic episodes of dyspnea with loss of consciousness and expired on the fourth hospital day.

AUTOPSY FINDINGS

The body was that of a fairly well-developed, poorly nourished, elderly colored male, measuring 70 inches in length and weighing approximately 110 lbs. The pericardium was thickened and there were two areas of calcification at the base, measuring 4x2 cm. each. The heart was moderately enlarged and weighed 425 grams. The epicardium was slightly thickened. At the base of the right posterior aortic cusp and in the sinus of Valsalva was a flat vegetation composed of laminated clot and necrotic material. This had

Submitted March 28, 1949.

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completely broken through the upper portion of the ventricular wall beneath the left cusp of the tricuspid valve. The surface of the vegetation was rather smooth and partially covered by the aortic cusp. It measured approximately 2x2.5 cm. The remainder of the endocardium was transparent and smooth. The valves were pliant. The myocardium of all chambers showed mild focal fibrosis. The coronary arteries showed moderate atherosclerosis but were patent throughout. Except for a large cystic prostate filled with brown stones, the remainder of the examination was essentially negative. The head was not examined. On microscopic examination of the heart there was seen a moderate amount of myocardial hypertrophy with many large polygonal cells with rectangular nuclei. In the interstitial spaces were seen a few polymorphonuclear leucocytes and increased numbers of interstitial monocytes. In the region of gross ulceration the surrounding myocardium contained large numbers of polymorphonuclear leucocytes filling the interstitial spaces. There was a thick zone of acute inflammatory cells surrounding a large area of ulceration and necrosis lying beneath the aortic valve cusp. Necrosis of myocardial cells was prominent at the border of this ulcerated area and the more central portion of this ulcer was composed of a basophilic homogenous relatively acellular material. Scattered in the edge of the ulcer borders were many clumps of cocci and some of the polymorphonuclear cells were seen to contain phagocytosed bacteria.

DISCUSSION

It has been previously mentioned that cardiac arrythmias are not uncommon in acute bacterial endocarditis but that complete heart block is rarely seen. Actually insofar as cardiac arrythmias are concerned it has been observed that alteration of the cardiac mechanism is more common in acute rheumatic fever than in bacterial endocarditis.[8] After consideration it seems strange that auriculo-ventricular conduction defects are not more often observed in cases of acute bacterial endocarditis, since it is well known that bacterial endocarditis most frequently involves the left side of the heart and the aortic valve primarily. Osler made the observation in 1885 that the right side of the heart was rarely involved by bacterial endocarditis and that the aortic valve was peculiarly suseptible.[9] The nature of the lesion and its close proximity to the conduction pathways should predispose to irregularities in rhythm.

In an earlier article Winternitz[10] reported electrocardiogram and autopsy findings in 69 cases of mycotic endocarditis. He reported no cases of heart block. Autopsy revealed cases with extensive ulcerative involvement of the aortic valve and some sections showed invasion of the bundle of His. In a later paper he reported a case of bacterial endocarditis with perforation of the right aortic valve cup into the membraneous septum which was destroyed in its upper part. The electrocardiogram showed lengthening of the P-R interval to 0.30 seconds but there was no evidence of complete heart block.[11] He stated, ". . . septic arrythmias are due to anatomic lesions of the specific system." In 1927 Senstrom[12] reported a case of complete heart block due to bacterial endocarditis and stated that he had seen several such cases. The microscopic examination of the heart in his case revealed inflammatory alterations in the endocardium and subendocardial tissue just over the auriculoventricular node and the a-v bundle, following it for the most part of its length, and separating and disturbing the Purkinjie system. This granulomatous tissue was composed of small round cells, plasma cells, and fibroblasts, and Van Gieson stain showed also true fibrosis. Apparently there was well advanced healing in this area. The electrocardiogram which had originally shown complete heart block later showed evidence of return to normal with normal sinus rhythm.

CONCLUSION

Although complete heart block is rarely seen with bacterial endocarditis it is to be remembered that such may occur. The conduction defect is undoubtedly due to anatomic invasion of the conduction tissue and not to vascular disease, allergy, etc. Although cases of partial heart block due to bacterial endocarditis are not unusual, complete heart block is a distinct rarity, indicating that a combination of locality and degree of invasion are necessary to produce such a defect in the cardiac mechanism. This combination apparently seldom occurs.

SUMMARY

1. A case of complete heart block due to acute bacterial endocarditis is reported.

2. The cardiac irregularity is due to anatomic disruption of the conduction system.

3. The rarity of such a lesion has been pointed out.

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Arteriovenous Fistula in Civilian Life*: Report of Four Cases

V. LESLIE TICHY, M. D.

ABNORMAL traumatic communications between arteries and veins are fairly common war injuries, as the cause is generally a rapidly moving small missile or fragment. However, the use of shotguns, industrial and automobile accidents resulting in flying missiles, and knife wounds may lead to these blood vessel injuries where the vessels are in practical apposition. Elkin[1] has reported several cases due to operative trauma, and one of those reported here probably belongs in that classification.

The fact that most of the fistulae produced in the last war were found and treated while the men were still in service is indication that recognition is not difficult if the condition is kept in mind. Any deeply penetrating wound may result in a fistula and the stethoscope should be used to examine all such wounds before discharging the patient.

When the injury occurs, there may be profuse hemorrhage, but deeply placed vessels may be damaged without much external bleeding. A thrill and bruit may be apparent upon the first examination but may be delayed for days. The most constant sign is the bruit, accented during systole but present throughout the cardiac cycle. If near the surface, the lesion produces a perceptible thrill likewise accented in systole.

The skin temperature is elevated in the region of a fistula, and if shunting of blood is not too great in an extremity, the distal portion is warmer than the opposite member. Extremities may be enlarged and if one lower extremity is larger than the other, and has at any time been the seat of a penetrating injury, a careful examination with the stethoscope is in order. A fistula occurring before full growth has been attained, may result in enlargement of an extremity in all dimensions. The surface veins may be enlarged, venous pressure may be increased, but where collateral venous circulation is good the elevation may be confined to the immediate vicinity of the fistula. Occasionally ulceration occurs in an extremity distal to a fistula. The heart should always be examined for increase in size and possibility of decompensation. When the fistula can be closed by digital pressure over it, there is a constant decrease, immediate, of the pulse rate, with an increase in the diastolic and generally the systolic blood pressure. This immediate slowing of the pulse on closure of the fistula, the so-called Branham sign, is a very constant finding.

The above considerations, with contributions by himself and others, are much more adequately described by Holman,[2] and by Allen, Barker and Hines.[3] More recent work on various other problems is not within the scope of this paper. The chief purpose is to present four interesting cases recently treated. Each of these has some unusual feature worth recording.

The Author

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CASE REPORTS

Case 1. This man, 30 years old, was first seen because of difficulty at work, due to discomfort in his right lower leg. He had a large scar just above his ankle and one below the knee, most of the discomfort being at the ankle. His wounds had been caused by shell fragments, and further examination disclosed a scar over the upper anterior thigh. A thrill was perceptible here and a loud harsh bruit was heard throughout the cardiac cycle, accented during systole. He was referred to the hospital where study disclosed a typical Branham sign, no enlargement of the extremity, heart within normal limits and a faint posterior tibial pulse. The bruit was very loud, well up into the groin and suprapubic area, being transmitted along the vessels. Operation disclosed a fistula of considerable size between the femoral vein and the profunda femoris artery, about 3 cm. distal to the origin of the latter. The opening in the artery was large, and the portion distal to the fistula was considerably decreased in diameter. The artery was ligated well above and distal to the fistula and transfixing ligatures were applied in addition. The communication to the vein was sufficiently elongated and thickened so that it was possible to ligate it, the femoral vein thus being left without appreciable constriction and with a wall of sufficient thickness. Regional veins requiring ligation were comparatively few. Recovery was uneventful and two years later the leg and ankle felt much better than they had preoperatively.

The vein can rarely be saved in operations for fistula, and as a rule it is of little im-

* Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the author. Submitted October 19, 1948.

portance. Here, however, it was of value because the two vessels concerned belonged functionally to different parts of the extremity. Ligation of the femoral vein would have embarrassed the circulation in the leg, in which the arterial supply was normal. While this case occurred during military service, it was one of the few not recognized and was discovered after the patient became a civilian.

* * *

Case II. E. B., a white male, of 26 years, suffered shotgun wounds of the right leg at the age of 16. In January, 1945, after induction into the army, he fell and was kicked in this leg. The calf became swollen, the foot mottled and blue. At that time the examining physician noted a thrill in the right calf. Swelling and ecchymosis subsided in three weeks, but on starting basic training the leg again became swollen and "stayed that way" until after release from the service. Subsequently he had continuous trouble with discomfort and a constant "thumping" in the right leg. When admitted on March 12, 1947, he claimed he was increasingly short winded and that his heart pounded unusually at times. Examination disclosed numerous small scars on the leg from buckshot wounds. The thigh was 1 cm. greater in circumference than the left, while the calf was 3¼ cm. greater than the left. There was some weakness of the muscles supplied by the deep branch of the peroneal nerve, especially the tibialis anterior.

X-ray of chest was within normal limits, while that of the right leg showed numerous small lead pellets. At operation, under spinal anesthesia the nerve supply of the anterior tibialis was found so included in the scarred vessels that some nerve fibers were sacrificed, though not all of them, The distal portion of the artery was much smaller than the proximal at the fistula, and it pulsated after ligature. An H type of excision was carried out, the arterial ends being secured with transfixion ligatures reinforcing the ties. Several large veins leaving the area also required ligation. Recovery was good, but some foot drop was evident and required a spring brace. Postoperative heart shadow was only 5 mm. less than preoperative. When seen six months later there was some reduction in the circumference of the leg, the anterior tibial was functioning though still weak. The patient was capable of normal farm work and felt better generally. He still preferred to use his leg brace a portion of the time.

While there might have been aggravation of the original lesion here with probable growth of more collateral veins after his injury during Army service, we feel definitely that the arteriovenous fistula was present following injury with buckshot. This is reported only because it is an example of a lesion that would easily have been found had the possibility been kept in mind.

* * *

Case III. T. S., aged 26, fell against the corner of a table, striking the right side of his head and sustaining a small laceration just anterior to his ear. Because of profuse bleeding he was rushed to the emergency ward of a hospital where bleeding vessels were tied off and the laceration sutured. Upon reporting for removal of sutures, the surgeon (not the original operator), noted a pulsation and felt a thrill in the area and informed the patient he would need operation. The patient heard the bruit, accented in systole, at all times and it was the source of much concern. Examination, eight weeks after injury, disclosed a small scar just anterior to the right ear, at the level of the external meatus. There was a raised area about 1 cm. in diameter, which was visibly pulsating and had a palpable thrill. There was a continuous machinery-like murmur, accented in systole. The thrill was obliterated easily with the finger, the pulse immediately falling from 84 to 76.

Collateral circulation not being a factor, the usual waiting period of three months was not required, and operation under intratracheal anesthesia was carried out about two months after injury. The dissection of the temporal vessels was time consuming because of the parotid gland and facial nerve fibers. The artery and vein were tied and transfixed with silk on either side of the fistula and the fistulous tract was removed in the usual manner. Recovery and healing were uneventful. At the time of discharge, the right forehead did not wrinkle and there was an almost imperceptible weakness of the orbicularis muscles about the right eye. Six months later there was full recovery with no remaining muscle weakness. The patient was much relieved to be rid of the continuous buzzing noise.

This location for fistula is not common, and the method of origin is exceptional. That a fistula between the vessels was produced by the blow seems unlikely and it was probably the result of suturing. Thus it may resemble the cases caused by operation, as reported by Elkin.

* * *

Case IV. A. B., a 28-year-old man, suffered shotgun wounds in both legs, causing multiple perforations with considerable bleeding. According to the record, complete debridement was done on both calves, with ligation of the left posterior tibial artery. Massive doses of penicillin were given. A few days later he was transferred to Crile Veterans Hospital. Examination here disclosed extensive open longitudinal surgical wounds in the posterior calves. The muscles were protruding, especially on the left. The circumference of the left calf was much greater than that of the right, but there was no visible pulsation. Palpation was difficult because of the large open wound. There was a blue area 5 cm. in diameter on the left heel and blue patches on the lateral three toes. No pulses were perceptible at the left ankle. Stethoscopic examination just lateral to the wound disclosed a continuous bruit. While the generalized calf swelling suggested the presence of a false aneurism the bruit was of the character indicating a fistula rather than simple false aneurism. Foot drop was complete on this side and there was anesthesia of most of the extremity below the knee. The right leg had multiple perforations and a long posterior open incision, but there was no enlargement of the calf. Faint pulses were palpable at the ankle. Stethoscopic examination disclosed a bruit here also, just lateral to the incision at the mid-leg. This was continuous and represented another arteriovenous fistula. The feet remained warm and under conservative therapy the wounds did well. Split thickness grafts were applied one month after injury after clearing superficial infection. Just six weeks after injury it was

noted that the fistula in the left leg had closed spontaneously, while that on the right was still present. Eleven weeks after injury, the fistula in the right leg was also found to have closed spontaneously. Grafts healed well and the patient was up and around on crutches, wearing a brace on the left. Subsequently he had a flap graft transplanted to the left heel, the toes having healed without surgery. Neither fistula recurred.

While arteriovenous fistulae in two locations are occasionally observed, spontaneous closure of both after an interval is a singular occurrence.

DISCUSSION

Among the cases presented here are three with remarkably unusual features. Veins are rarely saved during operation on these lesions, but it was highly desirable to preserve the femoral vein in the first patient. The good result, with alleviation of lower leg symptoms, made the effort worth while. The temporal fistula was noteworthy because of the manner of causation. The last case, with spontaneous closure of two separate fistulae in the same patient is further proof that conservatism is sometimes the best policy in vascular surgery.

Two of these cases were diagnosed before being seen by the author and the vast majority of such lesions can be easily found if kept in mind when examining penetrating wounds, no matter how small.

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Toxic Reaction to Aureomycin

Aureomycin was administered to a patient with cholangeolytic obstructive jaundice thought to be on a virus infection basis. Three thousand milligrams were given daily for six weeks. A toxic reaction was then encountered.

Aureomycin may give rise to a toxic reaction consisting of swelling of hands and forearms, ankles and feet, and face, and a papulovesicular and vesicular eruption between the thighs, about the anus, and underneath the breasts (in a female patient). These findings may be associated with a burning sensation of the mouth; a burning sensation retro-sternally from the esophagus; and a burning sensation within the rectum and about the anus. The mouth mucous membranes may show congestion, and discrete white plaques on the buccal mucosa. There is immediate relief of symptoms and disappearance of all signs when aureomycin is discontinued.—Jacob A. Riese, M. D., Jersey City, N. J.; Jour. of Medical Society of New Jersey, Vol. 46, No. 10, October, 1949.

Management of Massive Bleeding from Peptic Ulcer

As has been previously stated, most cases of massive hemorrhage stop bleeding under appropriate medical management. However, there is always a small per cent that will continue to bleed and prove fatal. Experience has shown that many of these patients can be saved by large quantities of blood and a good surgeon. It is the responsibility of the medical man in cooperation with the surgeon to recognize these special cases. Certain criteria, that have been developed by various investigators, may be used in the selection of the particular case for emergency surgical treatment. They may be summarized as follows:

(1) In that case in which hemorrhage continues in spite of a strict medical regimen or when hemorrhage recurs after a temporary cessation, surgery should be considered.

(2) Age has been shown by a number of authors to be a factor in mortality. It is well known that the great majority of deaths from massive hemorrhage occurs in patients of 50 years or older. It becomes necessary to observe closely an apparently mild hemorrhage in the older person.

(3) Patients who have had multiple hemorrhage do not seem to do well on medical management and so this fact should be considered for what it is worth in deciding what is best for the patient. The first hemorrhage rarely ends fatally.

(4) Also experience has proven that the chances of recovery are related to the duration of the hemorrhage. Very few survive if heavy bleeding persists for 48 hours or more. So this fact bears weight in the selection of the case for surgery.

(5) It must be remembered that the rate of hemorrhage, with its effect upon circulation, is the most dangerous factor in these cases. The presence of hypotension and signs of shock in spite of repeated blood transfusion make surgery more or less imperative.

It should be emphasized that only those patients who are bleeding to death in spite of our best medical program should go to surgery, regardless of the fact that the exsanguinated patient is an extremely poor surgical risk.

In the case that makes a fairly prompt recovery from an episode of massive hemorrhage, it has been our practice to consider the case as a medical problem. However, more recently we have inclined to the opinion that certain of these cases should have elective surgery. We use some of the above criteria as our guide to a great extent, in the selection of these cases. In brief we consider that individual of 50 years or more who has had a rather difficult time as a result of the hemorrhage, and whose history indicates a chronic type of ulcer, as a candidate for elective surgery.—E. B. Reed, M. D., Nebraska State Medical Jour., Vol. 34, No. 9, September, 1949.

Prolonged Factitious Fever

EDWARD M. KLINE, M.D., D. KIRK SPITLER, M.D., and HOWARD H. HOPWOOD, M.D.

MALINGERING was discovered in a student nurse after an undiagnosed illness of fifteen months' duration. Although malingering had been suggested from time to time, it had been discarded as wholly unlikely in one with such a good professional background and past medical record. Furthermore, she had submitted to two abdominal operations, a muscle biopsy and innumerable unpleasant diagnostic and laboratory procedures. One of us who had seen the patient visited with Dr. Jerome W. Conn of Ann Arbor, Michigan. Dr. Conn recounted the history of a nurse who had malingered in a fantastic way (since reported)[1] and had submitted to an exploratory laparotomy. This immediately recalled the case being reported and eventually led to the proper resolution of this patient's complex illness.

CASE REPORT

The patient was a 21-year-old white female student nurse who entered the hospital September 3, 1943, with the complaint of fever. She stated that she began having transient pains in the knees, elbows, wrist and ankles about three weeks previously and during this time had noticed a temperature elevation as high as 39.5° C. two or three times each week. Symptoms of weakness and fatigue she attributed to poor sleeping habits while on night duty. She had lost twelve pounds in weight during the past two months. The night before admission she had slight epigastric pain and had vomited on one occasion.

There had been three hospital admissions during 1942. Tonsil tags were removed on March 30. Two other admissions to another hospital in the city were on August 23 and September 1 for identical complaints of nausea, vomiting and lower abdominal pain. Appendicitis was suspected on both occasions, but the symptoms subsided quickly and without specific treatment.

On January 12, 1943, she was admitted to the hospital again for complaints similar to those that she had had before. This time there was definite localized right lower quadrant pain and an appendectomy appeared to be indicated. The appendix when removed was found to be normal. Throughout her hospital stay of 26 days she complained of intermittent nausea with occasional vomiting, general malaise and headache. A thorough work-up including all the usual laboratory studies showed nothing abnormal. Her temperature varied irregularly between 38° C. and 39° C., but it returned to normal during the last few days of her hospitalization.

Two weeks later she was readmitted with a recurrence of symptoms. Her physical examination was the same as on the previous admission except for a faint systolic cardiac murmur which had not been noted before. Her temperature was 39.5° C. for the first three hospital days and thereafter it varied between 37° C. and 38° C. Her complaints at this time were similar to those of her previous admission. Treatment was again symptomatic except that sulfadiazine was given for one week. Subacute bacterial endocarditis was suspected, but it could not be confirmed and she was discharged on her nineteenth hospital day.

A twelve months' period of hospitalization began on January 7, 1944. Since her discharge two and one-half months earlier she had been free of nausea and vomiting and had been able to engage in somewhat restricted general duty. She stated that about one week before this admission she had had abdominal cramps with frequent bowel movements and temperature elevations to 38.6° C. and 39.5° C. Again her physical examination was normal, and the heart murmur was unchanged. While in the hospital her temperature varied irregularly from 38° C. to 40° C. and her pulse rate ranged between 70 to 100 per minute. There was nausea and vomiting which was often severe enough to necessitate the administration of fluids parenterally. A number of visiting and resident physicians and several consultants from other institutions became interested in her case. The diagnoses considered were subacute bacterial endocarditis, tuberculous peritonitis, undulant fever, disseminated lupus erythematosus and Hodgkins disease.

Many laboratory examinations were made. Agglutination tests for typhoid, paratyphoid, and undulant fever were repeated on seven occasions, the highest titer being 1:150 with Brucella melitensis and abortus. Thirty-one blood cultures were made on this admission. Twenty revealed no growth, six grew alpha-hemolytic

From the Medical Service, Saint Luke's Hospital, Cleveland, Ohio. Submitted April 25, 1949.

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streptococcus, two grew Staphlococcus aureus, and three were contaminated. Repeated cultures and examinations of the stools for parasites were negative. A lumbar puncture was negative. Guinea pig inoculations of blood on two occasions and urine on seven were negative. The sedimentation rate remained normal. The electrocardiogram was normal. On account of pain in the flank and microscopic hematuria, intravenous and retrograde pyelograms were done and these were normal.

Abdominal pain with intermittent nausea and vomiting persisted and an exploratory laparotomy was performed on March 11, 1944. Careful inspection and palpation of the abdominal viscera revealed no pathologic lesion.

At this time a neighboring institution had penicillin available for treatment of subacute bacterial endocarditis, and on April 22, 1944, the patient was transferred for this therapy. She received 10,000 units every three hours (1.12 million total) and while under treatment the temperature fell promptly to 37.5° C. but rose again to 38° C. and 38.5° C. as soon as the antibiotic was discontinued. Periarteritis nodosa was considered and a sartorious muscle biopsy was made, but it showed nothing pathological.

On account of the high fever and relatively low pulse rate and because the patient failed to show the progressive deterioration anticipated from this prolonged febrile illness, malingering was again suggested. It was decided to take her temperature by mouth occasionally and immediately after a high rectal temperature had been recorded by the floor nurse. When this was done the mouth temperature was found to be normal. At about the same time it was discovered that the serial numbers of the rectal thermometers given the patient did not correspond to those returned by her. When confronted with this evidence she admited her malingering and left the hospital immediately. On this account we were unable to evaluate her problem from the psychiatric point of view, and we were at a loss to explain her extraordinary behaviour. It was reported to us that she gained 20 pounds in weight after her discharge from the hospital and so far as we know she has remained in good health.

DISCUSSION

This case serves to point out how rectal temperatures, which are generally believed to be more accurate and less susceptible to manipulation than oral ones, can be "fixed" easily by having a second thermometer set at the desired reading and exchanged for the one given to the patient each time the "temperature" is taken. This technique has been described previously by Schnur[2] who reported four cases of malingering with long continued fever, three of whom were nurses.

The many borderline laboratory findings were never explained satisfactorily. This report may serve to remind other physicians of the possibility of malingering in dealing with bizarre and undiagnosed illnesses.

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KEEPING UP WITH MEDICINE

• MUCH more attention should be paid by physicians to the psychic problems which develop from economic stress and bad nutritional states the year following a pregnancy. This is fully as important as the prenatal care in terms of the mother's happiness and the emotional security of the child.

* * *

• IF people react slowly to the problems of their government in matters that affect their own pocketbooks, they are all the more slow to be moved by attempts to improve their health. In our public relations, we physicians must study the physiology of the conditioned reflex for our nervous systems have been conditioned to react differently to the common words of our language than the way we may expect the other 148,850,000 citizens of the U. S. A. to react.

* * *

• THE next step in improving the lot of our children will be not to produce longer trained specialists in obstetrics and pediatrics but to so improve the nutritional state of our prospective mothers so that "delivering babies" will not be necessary. Women should give birth to their babies.

* * *

• THEY now propose to approach the problem of the treatment of the alcoholic from the endocrine angle. This proposal is based upon the experimental observations with adrenal extracts and seems fully justified from the viewpoint of theory. Interestingly enough it supports the contention of A. A. that alcoholics are victims of an allergic-like mechanism. This gives them the laugh on the allergists who laugh at them and their "simple concept" of allergy.

* * *

• I CANNOT accept the Russian concept that old age has a single cause. It is equally important that aside from certain diseases of the ear and eye, there are no diseases of old age. Our so-called degenerative diseases are all diseases of late middle life.

* * *

• A SURPRISINGLY high percentage of pregnant women develop heart murmurs during the last few weeks of the pregnancy. As yet we have no valid explanation for these.

* * *

• FOR practical purposes, we may think of the anti-histaminics giving good results in those types of allergy where the histamine is free and removed from the site of its origin as in hay fever and hives and as of being very little use in those instances in which the histamine is retained in the tissue of the shock organ as in the bronchi of asthma.—JONATHAN FORMAN, M.D.

Preoperative Preparation of the Gynecologic Patient

STUART A. SCHLOSS, M. D.

ONE should never believe that gynecologic surgery differs from any other surgery in fundamental concepts. Thus all principles of preoperative care of gynecologic patients should conform to the care of preoperative patients as outlined in all general surgical procedures. There are certain special procedures that apply specifically to the gynecologic patient. These will be considered in the course of this paper.

A word of caution should be introduced in gynecologic diagnoses. The greatest errors of diagnosis result from a slovenly approach to a case, an omission of maintaining standards all of us learned as medical students. Errors of omission and errors of commission are equally dangerous.

A careful history is essential to good diagnosis and treatment. The female genital organs happen to be a part of a person who is also the proud possessor of a cardiorespiratory system, neuromuscular system, bones and joints, gastro-intestinal system, and urinary system. There is no gain for the patient if she dies as the result of good surgery because of cardiorespiratory break-down or crises of any other of the systems aggravated by surgery. Many times the reaction of the patient to history taking might arouse caution in the doctor and force him to rely upon his physical findings alone. Such a circumstance all too frequently occurs in a woman who is attempting to hide the presence of a pregnancy and who is desirous of any operative procedure in the hopes that the pregnancy will thus be terminated. Sometimes, too, the patient is highly prudish and thus will falsify unintentionally her story.

The physical examination then enters the picture. There is no short cut to trained gynecologic fingers which can recognize gynecologic diseases on pelvic examination. The requirement remains and will remain constant practice. This happens to be just another place in medicine where past training in which independent examination of the pelves compared with operation findings, remains the paramount censor and instructor. Pelvic examination is not enough alone to warrant operating upon a patient. A physical examination of the heart, lungs and entire body should be completed before anyone has the right to subject this patient to anesthesia or surgery. No detail is too small to be considered. After having done the complete examination, it is desirable to decide and anticipate the extent of the surgery and possible complications. Every attempt should be made to eliminate any hazard. An example of this would be anticipating the proximity of the ureters to the lesion. If the ureters are too close or anatomically closely tied in with the lesion, ureteral catheters should be inserted preoperatively. This latter procedure should not be routine. It does add a small degree of unnecessary trauma.

The laboratory findings should cover routine provinces. The least that is acceptable is an urinalysis and a complete blood count which includes red blood count, white blood count and smear for differentials. A serologic test for syphilis should be done if possible, before operation. Any other test considered important in the case should be completed and interpreted before the patient goes to the operating room. Of special importance is the manner of selecting a time to operate upon an infected pelvis. We still rely upon the sedimentation time for this. As the sedimentation time approaches normal, there is greater safety.

Now is the time to check over the chart and be sure that the surgeon is immune from malicious legal liability. An operating permit should be signed. If any mutilating operative procedure is carried out by primary intent, such as procedure to stop future pregnancies, the permission of both husband and the wife must be obtained. If a therapeutic abortion is anticipated, again the permission of both the husband and the wife must be obtained and in writing upon the chart.

We are now in the year 1949. Up to the present time, great strides have been made to simplify our diagnoses and surgical procedures so that less risk is taken with the patient's life. We possess better knowledge of the body and its reactions. We know much more about

The Author

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fluid balance. Antibiotics can be administered easily. Anesthesiology has advanced by leaps and bounds. Blood transfusions are better administered by virtue of finding additional typing, thereby causing less reaction. Blood banks have come into existence supplying, on a moment's notice, quantities of blood. X-ray diagnostic procedures have improved. All of these advancements are of tremendous value to the surgeon. In anticipation of surgery, each gynecologist using all the instruments and implements which are available, is able to calculate the risk content of his case. Today we can perform surgery on the female organs that would never have been dared in previous times.

With all the factors up to this point considered in the individual case, we now are concerned with the immediate preoperative care. In the event of shock to a profound degree, we have learned that surgery is a mortal risk unless we have combatted this shock. For this purpose, we must rely upon an adequate blood supply, frequent blood counts, intravenous fluids and sometimes plasma. A word of caution is in order here. In the administration of intravenous fluid, it is advisable not to use too much sodium chloride which in itself can waterlog tissues and enhance shock. Chronic secondary anemias are treated by preoperative blood transfusions. The cardiac case is checked as completely as possible. The greatest possible degree of compensation is secured by the use of appropriate drugs and extended rest in bed. The diabetic has her status determined. Glucose tolerance tests are used for this. Insulin treatment is regulated. An attempt is made to send the patient to the operating room with a small spillover of glucose in the urine but with no azotemia. Other special general conditions should be improved as much as possible. For this purpose, it is wise to trust a good consultant. When this man is well versed in the field which covers the systemic complaints of the patient, he can contribute much to the successful preparation of the case. One thing is sure, he certainly dilutes the anxiety of the gynecologist. Good consultation is good medicine.

When the non-emergency case enters the hospital the day before operation, she should be given a comfortable preoperative night. Apprehension can be diminished by a sound sleep. No other substance is given orally after midnight preceding the operation. In the morning a soap-sud enema is administered to evacuate the bowels in order to reduce distention and to permit the patient to tolerate a relative constipation for approximately three days.

One hour before operation, morphine and hyoscine are administered hypodermatically. The morphine should be in as small a dose as possible to permit a feeling of well-being. The larger the dose of morphine, the greater is the danger of depression of the respiratory centers. Hyoscine is given in a dosage of gr. 1/200. Its purpose is to diminish secretions and to produce amnesia. At about this same time, a catheter is inserted into the urinary bladder and anchored into place if an abdominal procedure is to be done. This step is of profound importance. A full urinary bladder can interfere with a low abdominal operation to an unbelievable degree. The presence of this catheter in the bladder is the only way that the surgeon can be sure that the urinary bladder is empty. The catheter is allowed to drain during the entire operation. The normal pad and linens of the operating table are sufficient to absorb the urine.

Vaginal, perineal and abdominal preps can be carried out in the room before the patient goes to surgery if a tight surgical schedule is being maintained in the hospital. These preps can also be done completely in the operating room. The patient is then transported to the operating room. Here she is put to sleep. If surgery is to be done per the vagina, the skin and vagina are preped by a five-minute cleansing with soap and water. This is followed by an irrigation of the soaped areas with at least two quarts of sterile water. Finally the area is swabbed with merthiolate applied by gauze sponges. This same sort of preparation is adequate if panhysterectomy is anticipated. Then a retention catheter can be inserted and allowed to drain. If the use of the ureteral catheterization is planned, now is time to introduce these. If abdominal laparotomy is to be carried out the abdomen is preped with soap and water by a five-minute scrubbing followed by merthiolate or any other antiseptic which has a low surface tension.

SUMMARY

This article can be summed up easily if I repeat a discussion of several months ago in which a group of obstetricians-gynecologists were arguing as to why the danger of cesarean section had been reduced. One stated that he thought the cases were better selected. Another man attributed it to more efficient blood transfusions, because blood typing was better and blood was more easily obtainable from a bank. Another man stated that he thought antibiotics were responsible because the margin of permissible error as regards infection was tremendously broadened. Another man felt that improved anesthesia with induction by pentothal sodium, the use of continuous spinal anesthesia, local field block, and cyclopropane were responsbile. It is the opinion of the author of this discussion that all of these factors individually and collectively contribute to a more successful preparation of the gynecologic patient.

Erythema Multiforme Exudativum

GRAFTON C. FANNEY, JR., M. D.

THERE has been renewed interest recently in the syndrome of severe erythema multiforme. This is especially true of the pediatric literature. Most of the cases have been reported under the names of erythema multiforme bullosum, erythema multiforme exudativum, and Stevens-Johnson's disease. I plan to give a brief description of the syndrome as it is described in the literature and as we have observed it at Babies' and Children's Hospital. I also wish to emphasize a few points that we feel may be important.

The clinical and laboratory picture is variable, but the criteria demanded by all are:

(1) Multiforme skin and mucous membrane lesions.

(2) Conjunctivitis.

(3) Systemic symptoms compatible with an infectious disease.

It may be, of course, that other cases which fulfill only one or two of these criteria are closely related, but the above clinical picture is characteristic—and rigid adherence to these criteria prevent the syndrome from becoming a waste paper basket for every undiagnosed skin disease.

The skin lesions vary from a few scattered macules to hemorrhagic bullae. Iris-like lesions and clear vesicles are the most common. They may be widespread but there seems to be a predilection for the extremities. They often appear in crops and may change markedly within a few hours. They usually clear without scarring in about seven days. There is no correlation between the severity of the syndrome and extent of skin lesions.

The mucous membranes of the mouth, trachea, larynx, genitalia or anus may be involved. Oral lesions are the most common and usually consist of tiny vesicles which break down to form ulcers covered by a dirty pseudomembrane. These are very painful and nutrition is frequently a problem The larynx and trachea may be involved severely enough to cause obstructive symptoms.

The conjunctivitis varies from mild injection to complete purulent destruction of the eye. A secondary Staphlococcus infection is a frequent complication and many cases of blindness are reported. Since the extensive use of chemotherapy severe conjunctivitis is unusual.

Systemic symptoms also vary markedly. Temperature may be only mildly elevated or run a septic course for several weeks. The patient may complain only of photophobia and sore mouth or there may be severe malaise and prostration. Most of these patients are acutely and seriously ill, however, and intelligent supportive treatment may be necessary to prevent a fatal outcome. Other cases are mild and the skin and mucous membranes may be involved out of proportion to the systemic involvement.

The laboratory data do not help much. The white blood count may be normal or elevated but there is usually a shift to the left. A typical count is 20,000 with 40 per cent unsegmented polys and 40 per cent segmented polys.

Aside from the eye, skin, and mucous membranes, there is evidence of involvement of other systems. There is frequently clinical and X-ray evidence of atypical pneumonia. Cold agglutinins are elevated. The pulmonary involvement may be severe and frequently is the major contributing cause of death.

Two systems which have not been emphasized in the literature but which we feel may be important are the cardiovascular and the central nervous systems. These patients show irritability and delirium out of proportion to their fever—frequently they show tremors and meningeal signs. Routine lumbar punctures have revealed pleocytosis in three of our nine cases. There is no evidence in the literature to support these findings and our series is too small to be conclusive.

We have much more evidence, however, of involvement of the cardiovascular system. Most of our patients showed tachycardia out of proportion to their fever. Many had muffled heart tones and a gallop rhythm. These were considered part of the systemic infection until an interesting case made us realize they were of more importance.

CASE REPORT

A 9-month-old white female infant was admitted because of fever, sore mouth, red eyes, and a scanty macular eruption. She had been treated with penicillin and sulfadiazine without apparent effect. Physical findings revealed temperature of 40°C., respiration 60, pulse 200. The

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The Author

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infant was acutely and seriously ill. The findings in the eyes, skin, and mucous membranes fulfilled the criteria mentioned above. For the first seven hospital days, course was very stormy. The temperature remained above 40°. The heart rate was fast and tones were of poor quality. During the next two weeks she improved gradually and by the twentieth hospital day seemed well. It was decided at that time to laryngoscope her in an effort to find the cause of a mild stridor that had existed since birth. During the procedure the patient suddenly expired. Autopsy revealed aneurysms of the coronary arteries that had ruptured giving a hemopericardium. The microscopic picture was that of periarteritis nodosum.

DISCUSSION

A review of the literature revealed another case that was strikingly similar to this one. Given this clue, we paid more attention to the cardiovascular aspect of our other patients and found that there was frequently clinical and electrocardiographic evidence of myocarditis. The most common electrocardiographic findings were low voltage, reversal of T waves, and prolonged PR intervals. At times these persisted on discharge. The patient with the most marked electrocardiographic changes developed transient hematuria and persistent hypertension.

This myocarditis may be non-specific and may be of the type that one sees in various severe infections. The involvement seems out of proportion to the other symptoms, however, and the two strikingly similar cases showing periarteritis-like lesions could hardly be coincidence. More investigations are certainly indicated. The whole subject of the relationship of virus infections to heart disease is interesting and underdeveloped.

Etiology is unknown. Blood, urine, feces, and fluid from the vesicles have been cultured on all types of media and injected into different animals without effect. Extensive antibody studies have been negative until recently when Dr. Finland[1, 2] found high titers against the herpes and psittacosis viruses in a few cases.

These findings, plus the clinical course and the occasional epidemics, suggest a virus infection. The frequent history of ingestion of sulfonamide and other drugs cannot be ignored and an allergic basis is a possibility. There is no good evidence to support this theory, however, and most patients recover even though the supposed guilty medication is continued. The frequency following vaccination, while not alarming, is too great to be accounted for by coincidence. The relationship to periarteritis is unknown, but is hypothesized that both conditions can be caused by a virus infection or an allergic basis.

As for treatment, one can only offer supportive therapy. Chemotherapy seems to be indicated to prevent secondary infection. In view of the frequent elevation of cold agglutinins we tried aureomycin in our last case, and in spite of a stormy onset his course seemed unusually benign. Of course, no conclusions may be drawn from one case. Limited activity may be indicated in view of possible cardiac involvement.

SUMMARY

A brief description of the clinical aspects of erythema multiforme bullosum is presented. It is emphasized that the syndrome is a systemic disease—not merely a skin disease. Evidence of frequent envolvement of the cardio-vascular system is presented, and it is suggested that careful evaluation of this system should be attempted in all cases.

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The Story Behind the Word:

Some Interesting Origins of Medical Terms

Whitlow:—This semi-medical term for paronychia is derived from the provincial English term "Whickflaw." Whickflaw in turn comes from the provincial English term "whick or quick" and the English word "flaw" meaning a crack, defect or sore. It literally means a flaw or sore about the quick of the nail.

Targus:—This anatomical name for the small cartilaginous eminence situated at the entrance of the external ear is derived from the Greek word "tragos" meaning a goat. It was so-called by the early anatomists because it is frequently beset with hair and thus bears a fancied resemblance to the beard of a goat.

Teleangiectasis:—This is a term descriptive of the condition and derives from the Greek words, tele or distinct; anggeion, a vessel; and ektasis or extension. It literally means an extension of distant or remote vessels.

Scrofula:—This condition formerly was quite common among children and most commonly involved the glands of the neck. The neck of the child often swelled until it resembled that of a pig, hence the name "scrofula" was applied, which literally means a "little pig." Scrofula is the diminutive of the Latin "scrofa," a sow.

Stethoscope:—Laennec at first called his instrument the baton, cylinder or pectoriloque. Later he changed it to the more euphoneous name of "stethoscope" derived from the Greek words "stethos" or chest and "scope," to view or explore.

—Harry Wain, M. D., Mansfield, Ohio.

Outgrowing Asthma

FRANK C. METZGER, M. D.

FOR many years young people between the ages of five and ten years have been brought into my office in pitiful condition, suffering from long-standing asthma, hay fever and urticaria. Very few of these cases have seen a specialist in allergy; a large number have not even been under the care of an M. D. They have been given home remedies, many of the most absurd nature such as cough remedies, and salves for allergic urticaria; even complications have gone untreated.

No worth-while efforts had been made to find causative agents and even well-known specifics for temporary relief had not been used. Why? The parents' answers were that they had been trying to "nurse them along until they *outgrew* their hay fever and asthma." Their ideas as to the age at which this was to occur were vague and their methods of procedure had often been suggested to the parents, not only by lay people but by physicians.

I have always felt that the concept of "outgrowing asthma" was incorrect, but it was not until I had accumulated, reviewed and analyzed thousands of case reports that I found worthwhile evidence to support my hypothesis. I now wish to report these findings and attempt to interpret them, employing the term "asthma" only; but since hay fever is also an evidence or manifestation of allergy, it could be regarded similarly, insofar as these results are concerned.

Four thousand case reports were examined. All subjects suffered from bronchial asthma. The controversial questions as to a difference in so-called atopic, acquired, extrinsic or intrinsic asthma has no bearing on this survey. I dislike the term cardiac asthma so no cases of dyspnea of cardiac origin are included.

I found that, with rare exceptions, every patient had had a remission of his symptoms; by this I mean that the asthma attacks suddenly or gradually disappeared for the time being. I then selected only those cases which had had remissions lasting one year or more. These were then separated into age groups and the following table shows the results.

Age at Time of Remission	Per Cent Showing Remissions 1 Yr. or Longer
5 - 10 yrs.	58%
10 - 20 yrs.	56%
20 - 30 yrs.	61%
30 - 40 yrs.	52%
40 - 50 yrs.	51%
50 - 60 yrs.	32%

This table means simply that between the ages shown, the indicated per cent of patients had remissions of one year or more. A glance at these per cents is sufficient to show that the incidence of remissions does not vary to a marked degree, except in the age group 50 to 60 years.

Submitted June 1, 1949.

The Author

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The slight variations in per cent in the first five groups, I think, can be explained. First, let me state a fact well known to allergists: Asthma occurs in an individual with a chest not in a chest alone. Individuals are subject to infections, accidents, changes in weather, exposure to smoke or irritating gases or fumes, and to a wide range of emotions. All or any of these may be factors in the total picture. Vary any one of these factors or the allergic exposure and definite changes take place.

At what age in American life do most of the above-mentioned variations take place? When children are 5 to 10 years of age, a great many fathers get better-paying positions, move their families to other homes, buy new house furnishings, often moving to other climates. All of this means: (1) Possible elimination of specific allergens affecting the children, or (2) changes in other factors, such as climate and maladjustment problems. I have seen many cases where maladjustment to certain school teachers, to certain of their classmates, has definitely affected their general health and consequently the frequency of allergic attacks. The simple removal to another school and more congenial environment definitely resulted in improvement and sometimes entire cessation of their attacks or, in other words, a remission. Of course, I have seen changes produce the opposite result, but such cases are not in the group under consideration, for such do not have remissions—they have exacerbations.

The same conditions apply largely to the second group 10 to 20 years.

In the group between ages 20 to 30 years, more changes take place. Between these ages most people marry, leave their former homes,

sometimes their cities and states. The diseases of childhood are behind them, the infirmities of old age ahead of them. Their general good health, both mental and physical, should allow their allergic tolerance to rise, and I believe it does. This, plus the changes mentioned, could very well account for the greater per cent of remissions in this group.

Beyond the age of 30 years we note a decline in the per cent of those who have remissions. Environment and climatic changes cease to be so numerous at this period of life: as time marches on, the effect of wear and tear upon the body, both mental and physical, becomes more and more apparent. Anxiety, based upon gradual loss of earning power, appears in the picture. Mental shocks and grief from loss of relatives and friends, heart trouble, constipation, arterial changes, arthritis with its accompanying aches and pains—all of these increase in number and severity. One would expect, therefore, if complications affect spells of asthma, that the per cent of remissions would decrease and we find that it definitely does.

In the light of this analysis, how then did the idea concerning children "outgrowing asthma" originate? There are a variety of reasons contributing to this widespread assumption. Years ago, asthma was considered an old folks' disease. Pure asthmatic seizures in young people were often—and still are—called "acute bronchitis," "cold on the chest," or "atypical pneumonia."

However, when Willie Smith and Susie Jones, aged 8 or 9 years, ceased having what, in their cases was actually diagnosed asthma, the parents told others they had "outgrown" the condition. Hundreds of persons who knew of these few cases had no means of following them up over a period of years and assumed that no recurrences took place. Generalizations from a few observations have been made in other situations, so why not in this one?

Remissions in older people are usually ascribed to the drug taken just before the remission occurred. Again, generalizations and erroneous reasoning gave a whole host of remedies credit for curative qualities they did not deserve.

The importance of early diagnosis and treatment of nearly all diseases has been stressed for years. In my experience, allergic conditions are no exception to this rule. But until, or unless, the general assumption that children tend to "outgrow" asthma is proven erroneous, many cases will not receive the correct treatment until after the disease has caused irreversible changes and has made alleviation or cure more difficult.

I fully realize that this survey leaves many questions unanswered. One question is: Do the remissions in the early age group tend to be longer or more permanent than in the other groups? Judging from case histories, I can state that there is no apparent difference in the time the remission lasts and the age at which it occurs until aged 50 is reached. After that age remissions are not only less numerous but also shorter in duration.

CONCLUSION

The sole purpose of this survey is to answer the questions, "Do children 'outgrow' asthma?" and "Is it justifiable to defer proper treatment to await this favorable occurrence?"

The answer to both is emphatically, NO!

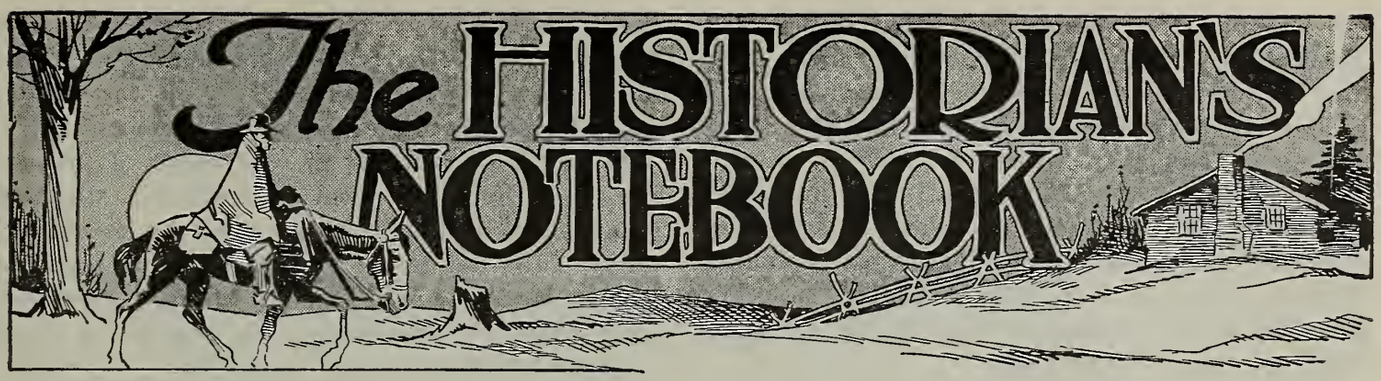
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Riedel's Struma

In 1896 Bernard Riedel, a surgeon in Jena, presented an original report on a thyroid gland that has become known as Riedel's Struma. This paper was presented sixteen years before Hashimoto's report. Riedel described the woody hardness of the gland, the fact that it becomes adherent to the trachea and surrounding tissues with the resulting technical difficulty in its surgical removal and its great similarity to carcinoma. Riedel's Struma is a chronic, fibrous, infiltrating, inflammatory process involving one and only occasionally both lobes of the gland. The fibrosis infiltrates around the gland into the muscles, fascia and nerves producing a bulky woody-hard tumor. The true etiology is unknown. There are many cases reported where the inflammatory reaction seems to center around a degenerating adenoma. An adenoma is said to never occur in Hashimoto's disease. Marshall believes that Riedel's Struma is possibly related to the terminal or heal stage of an infectious type of thyroiditis and entirely unrelated to Hashimoto's disease. The disease occurs more frequently in women than men and in a younger age group than Hashimoto's. The onset is insidious and painless. The tumor grows slowly and it may be several years before the patient will detect its presence. There is no change in the metabolic rate unless there is total destruction of both lobes of the gland. Because of the hardness and infiltration into the capsule and surrounding tissues, the preoperative diagnosis almost always is carcinoma. Due to the absence of a natural plane of cleavage, the technical difficulties of operation are increased.—Drs. Wm. C. Cantey and E. K. Kinder, Columbia, S. C.: Jour. of South Carolina Medical Assn., Vol. XLV, No. 10, October, 1949.



High Spots of Ohio Homeopathic History 1890-1949

LUCY S. HERTZOG, M. D.

THE history of the earliest work of the homeopaths in Ohio was written* by me in 1940, and was of the period between 1835 and 1858. In this year, 1949, I am given the period including the gay nineties up to the present time, in which to give a comprehensive record of what the homeopathic school of medicine did in Ohio in that time, and what was done to it. History cannot be confined within arbitrary dates, and periods overlap. In the brief time and space allowed, only the high spots can be touched, and the record of necessity will be inadequate. There will always be frontiers in medicine. Every great scientist of any school who promoted innovations in medicine since recorded history, was more or less victimized by human passions and prejudices as they bravely searched through blind trails to discover facts, and cures for human ills contrary to tradition.

In this last hundred years we have seen the greatest advancement in medicine of all time, along all lines. We could use the gifts of the two-faced god Janus who had the ability to look backward and forward at the same time, as we contemplate the past, the great changes in medicine, in the American people, and in our country.

What a cavalcade could pass before us of changing America and living in this era! The wealthiest of those early days knew nothing of the conveniences now common in the poorest homes. Today everything stops when the electricity goes off. What an advance it was, when the doctor asked for hot water and used it freely! We would view as incredible the unsanitary flowing beards, side burns, which with mustaches, were standard equipment for doctors and laymen. The men carried half pound watches with hair chains. For years the wrist watch was considered sissy. Try to get them away from doctors today.

Two or three generations ago a boy read medicine, with a preceptor. The reading was often sketchy, for he had a wide range of other duties and usually smelled horsey. But that system had much to recommend it, and in principle is still valuable today.

HAHNEMANN—FOUNDER OF HOMEOPATHY

Where did Homeopathy come from? What does it mean? Who was its founder? What has it accomplished? The man who fathered it and whose genius discovered and formulated the law that "like cures like" was Samuel Christian Frederick Hahnemann born in Meissen, Saxony, in 1755. Hippocrates, father of all schools of medicine, said among many other similar statements 400 years before Christ, "By similar things disease is produced and by similar things administered to the sick they are healed of their diseases." The idea reappeared with Paracelsus, a profound scholar who lived 400 years ago. He said, "There is a remedy for every disease, the less the quantity, the greater the effect. Never was a hot disease cured by cold, nor a cold one cured by heat." Many caught glimpses of the truth, but Hahnemann rediscovered it and made it practical by study and experiment for many years, and by proving remedies on the healthy human being, before he announced this definite rule of medical practice in 1790. He proved 99 remedies on himself.

Hahnemann studied medicine in Leipzig and Vienna, was always a recognized member in good standing of the so-called Regular School of Europe, and was court physician at one time. In 1833 he was notified of his election

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Presented at the Sixty-fourth Annual Meeting of the Ohio State Archaeological and Historical Society, April 23, 1949. References: William Harvey King's History of Homeopathy; Dr. B. B. Kimmel's Records; Dr. B. C. Woodbury; A. I. H. Journals of 1947.

* Published in the Ohio State Archaeological and Historical Quarterly, October-December, 1940.

by ballot as a member of the New York Academy of Medicine. The reason given was that he was the founder of Homeopathy, and he died an honorary member of this New York Society. Hahnemann was eminent as a student, chemist, physician, translator, innovator and reformer. He had a remarkable memory and was master of eleven languages including Hebrew. He was a profound scholar, a seeker after truth, not a heretic. His books on chemistry are classic to this day.

It has been claimed that the homeopaths are descendents of the Thomsonians or Eclectics or both. Both claims are false. Hahnemann was fourteen years older than Samuel Thomson who was born in New Hampshire. Thomson was one of six, lame from birth, raised in a rough barn in stark poverty, and was put to work at the age of four by a violent tempered father. At the age of ten he had one month's schooling. A kind neighbor woman who had knowledge of plants and doctored the neighborhood, took the little boy with her to gather herbs. He loved plants and chewed and tasted them and was familiar with their uses. After his marriage he lived near a doctor for seven years and learned all he could from him. He once opened an office in Boston to practice medicine. Thomson's book "New Guide to Health" went through several editions by 1833 so he must have created some stir. He and Hahnemann may have heard of one another, but never met. It was just a curious coincidence that they were contemporaries. They were completely different in education, mentality, personality, background. The great doctors and scholars who followed Hahnemann's teaching would have had no special use for Thomson. The fact that the Eclectic College in Cincinnati established a chair of Homeopathy for one year only and that so many Eclectics were converted to Homeopathy in that year may explain the claims of outsiders that the homeopaths stem from Eclecticism.

HAHNEMANN—REFORMER OF MEDICAL CHAOS

In Hahnemann's day medicine was in a deplorable state of chaos. The abuse of emetics, purgatives, cautery, blisters, leeching and bloodletting knew no bounds. The revolting prescriptions contained anywhere from 60 to 400 ingredients which, plus the above treatment, made a torture chamber of the sickroom. Hahnemann disapproved violently of all of these barbaric treatments, publicly and privately. This made the apothecaries so mad he dared not trust them with his own prescriptions, and this persecution was so bitter that he did not stay long in one place, so persecuted they the prophets. For fifteen years the Duke and Dutchess of Anhalt-Cother befriended him as he wrote and studied and made cures that gave him fame all over Europe. In 1810, he published his *Organon*. In it he termed his method of treating disease, Homeopathy, based on the fundamental rule "Let likes be treated with likes."

He achieved reforms in vast fields of preventive and hygienic medical methods, startling innovations in 1790, but accepted by everybody today. He did not plan to create a separate School of Medicine. Due to his last marriage to a titled French woman, he received a royal ordinance granting him permission to practice in Paris so that he, the recluse and scholar, became the fashionable physician in the gayest city of the world, with patients brought to him from all over Europe and even from the United States. He practiced until at the age of ninety, when covered with honors, he passed on to his reward.

HOMEOPATHY ENTERED OHIO

Homeopathy was brought directly to America by authenticated students of Dr. Hahnemann, brilliant doctors, graduates of German Universities. Homeopathy was first introduced into Ohio in 1836 and Dr. William Sturm, a pupil of Hahnemann's who began practice in Cincinnati in 1839, was the first of the cultured, fine homeopaths in that region. The second to come was Dr. Joseph H. Pulte, a man of great culture, education and skill. He was born in Germany, son of a distinguished physician. He won much acclaim in the successful treatment of the cholera epidemic of 1849. On one occasion when a distinguished Greek visited Cincinnati, Dr. Pulte was the only citizen to be found who could converse with him in his native tongue. Homeopathy became well established and while many homeopathic physicians had come to Cincinnati by 1872, the demand for them was increasing. The early homeopaths had to be converts from the Regular schools principally, for they had no schools of their own. Because the homeopathic doctors were barred from the societies and hospitals of the old school, the homeopaths were forced to create colleges, societies and hospitals for themselves.

HOMEOPATHIC COLLEGES

There were only six homeopathic colleges in the United States, one of them being The Cleveland Homeopathic, when in 1870, Dr. J. D. Buck and Dr. S. R. Beckwith arrived fresh from college work in Cleveland, and decided that Cincinnati was a favorable field for a new homeopathic college, so they proceeded to organize it. Owing to his eminence and also to his offer of financial help the new college was named for Dr. Pulte—"Pulte Medical College." Its first session began in the autumn of 1872, ending in February, 1873, embracing a term of twenty weeks, which constituted a college course at that time.

Pulte College established the graded plan of instruction, thus departing from the set method

of giving a duplicate course of lectures for the two sessions required for graduation. This resulted in more thorough instruction and has become the established custom in all colleges. In a few years it became a co-educational institution.

Although Pulte College suffered financial reverses for some years from which it was rescued and the title to the property secured by Dr. William Owens, Sr., the scholastic efforts of the college were a success, and it was known to be one of the best homeopathic colleges in the country. It was recognized as a Registered college by the New York State Board, which recognition admitted its graduates to examination by that Board for a practitioner's license without attending a New York college. Its graduates never failed in examination by the Ohio State Board. One of Pulte's cultured and brilliant graduates was Dr. Charles E. Walton of Cincinnati, who was president of our National Association—The American Institute of Homeopathy in 1900, the year Hahnemann's beautiful monument was dedicated in Washington, D. C.

The time arrived when it seemed that in the interest of conservation and efficiency, one college could best serve Homeopathy in Ohio and help meet the constant demand for more homeopathic physicians. So, in order to strengthen the cause, the Faculty and Trustees consented to the amalgamation of Pulte College with the older Cleveland College in 1911 under the title of Cleveland-Pulte Homeopathic College.

Cleveland College was planned by the homeopaths in 1849 but it did not materialize until 1850 when the Cleveland Homeopathic Medical College opened its doors at the corner of Prospect and Ontario, with sixty students, an able faculty and a fine course of study planned. It was the second institution of its kind in America and was not an outgrowth of the Allentown, Pennsylvania, Academy as some have claimed. By 1852 the course was extended to three years of study, and two courses of lectures. The name of the college was changed in 1857 to the Western College of Homeopathy. Around 1870 it was changed again to the Cleveland Homeopathic Hospital College.

The question of co-education rose and fell and rose again, and in 1871 the doors of this college were opened to women never to close again, where they were to have equal rights with those of men.

In the year 1869 the Cleveland college adopted a "Memorial on Education" which was sent to the Medical Society of Ohio and of Cuyahoga County stating that the need of a higher standard of medical scholarship was too universally apparent to require proof; that the demand for improvement should spring from the great body of the profession and its county, state and national societies, and that it was necessary to secure the concurrence and cooperation of all of our medical schools.

The homeopathic medical societies of Ohio and its hospitals heartily endorsed this effort to elevate the standard of medical education, and in the third decade of the history of the Cleveland Homeopathic College several distinct advances in its curriculum and requirements for graduation were made. To the credit of Homeopathy be it known that the transition from two to three, and from three to four-year terms was first advocated and required by the homeopathic colleges.

Along in 1885 and 1890 there were at least 15 colleges in the United States teaching Homeopathy. A few were chairs in Universities. At this period there was a radical reorganization of all medical schools on a higher plane and Homeopathy did not lose any greater proportion of its colleges than did the Regulars and Eclectics. The graduates of homeopathic schools are men whose work is of high standard, men who are nationally, even internationally, known as efficient pathologists, sanitarians, surgeons and prescribers, the equal of the graduates of other schools in Army, Navy, Public Health Service, well prepared for the practice of medicine anywhere. At least two of them were personal physicians to our Presidents, and the family physician of the Royal Family of England has been a homeopath since the days of Queen Victoria.

The Cleveland Homeopathic College in the 1880-1890 decade was considered probably the best in the country, because its experienced teachers were men of such ability as to force this recognition. But the time arrived in 1890 when these men could work together no longer. On one side were Drs. Schneider, Jones and Baxter, on the other, Drs. Sanders, Biggar and Phillips, with Dr. Biggar the central figure in the dissension. Their difficulties culminated in a division. The larger body formed a competing college on Bolivar, back of the hospital and erected a new building to house it under the name of the Cleveland Medical College while the mother college operated under the name of the Cleveland University of Medicine and Surgery.

Among the many competent teachers in the Cleveland group of homeopaths, the new college could not find any one to fill the professorship of gynecology, still held by Dr. Biggar in the old college. After a nation-wide search for the right man, Dr. James Craven Wood who had taught the subject for eight years at the University of Michigan, was chosen. He came to Cleveland in 1894, where he rounded out thirty-two years of teaching in medical colleges. Upon Dr. Biggar's resignation after a few years, the two colleges reunited under the name of the

Cleveland Homeopathic Medical College, which graduated its first class in 1898.

HOMEOPATHIC HOSPITALS

As Homeopathy progressed, hospital facilities became an imperative necessity in cities and in connection with teaching centers. In Cleveland Dr. Seth R. Beckwith, a convert to Homeopathy and the surgeon for the Lake Shore and Cleveland, Columbus and Cincinnati railroads, established the first organized hospital in Cleveland in 1856. This Cleveland Homeopathic Hospital on Lake Street accommodated twenty patients, primarily those injured on the railroad. In Cincinnati, Bethesda Hospital was started by Dr. Samuel R. Geiser and Dr. Christian Golder, and has been the center of homeopathic activity in that city.

In 1860, St. Vincent's Hospital was completed and as physicians of both schools seemed welcome, the one on Lake Street was closed and St. Vincent's was the only hospital in Cleveland. In succession the homeopaths used it, then a Protestant hospital opened on 55th Street, and later the Humiston Institute.

But in 1873 the homeopaths purchased a site located on Huron Road for themselves, and incorporated in 1874 under the name of the Cleveland Homeopathic Hospital. It repeatedly became inadequate and additions were built again and again, but rapidly increasing demands for more hospital facilities made the decision to sell and arrange for more adequate quarters a necessity. The old buildings were bought in 1925 by the Bell Telephone Company. The Board of Trustees eventually bought a four-acre plot which was part of the Rockefeller estate at the corner of Terrace and Belmore in East Cleveland, for $50,000.

The legal right of the homeopaths to control the hospital was fixed by Journal Entry in the Court of Appeals No. 4492, April 7, 1924, and this right is perpetual. This ended many historic frays.

Until the new hospital could be built, the old hospital moved into two large connected residences belonging to the Severance estate at Euclid and East 89th Street still operating under the name of Huron Road Hospital and it remained at this location until the new hospital was completed at Terrace Road site, which was opened for patients in August, 1935.

This hospital, still operating under the name of Huron Road (the friendly hospital) is free of debt and dissension. It ranks with the ten best hospitals in Cleveland and is one of the leading centers in the United States for homeopathic education.

At the death of J. D. Rockefeller, Sr., his son, presented to the hospital an extra four acres which give ample space for needed expansion.

Huron Road Hospital has served the city of Cleveland adequately for fifty years. Huron Road's nursing school is known by the official title of the Cleveland Training School for Nurses. It was founded in 1884 and it is the oldest school for nurses training in Cleveland. The standard of work is of the highest, and it has always been a recommendation in itself to be classed as a Huron Road nurse. Recently, the Huron Road Hospital Society has changed the name of the Nursing School to the "Huron Road Hospital School of Nursing." It has graduated 821 nurses in the 64 years.

Through the years Huron Road Hospital had in succession four dominant leaders of extraordinary qualities: Nathaniel Schnieder, H. F. Biggar, James C. Wood, and Scott C. Runnels, in order of service. No words can express their value to the world and to the cause of Homeopathy.

OHIO HOMEOPATHIC STATE SOCIETY

It took a period of thirteen years of talk and planning to get an Ohio Homeopathic State Society started in September, 1851. There are no records of meetings in 1852-1853, but in 1854 a few met at Columbus, which was chosen as a permanent meeting place then, but later, they met in other places. We can hardly comprehend the difficulties of travel, suffered by doctors attending meetings in those early days. Dr. Peter Allen described the appearance of doctors arriving at their destination as resembling "a company of men crawling out of a canal where they had been excavating on a rainy day."

It took a week to reach Columbus from Cleveland in the fifties. Those men were used to distances and to swimming their horses across a stream and riding home arriving with clothes frozen stiff about them. "How times have changed," soliloquized a ninety-four-year-old, Mr. Mowrey of Geauga County in 1927. "Dr. L. A. Hamilton of Chardon brought me into the world. He drove from Chardon to Montville, eight miles through deep mud over almost impassable roads in 1833 and his fee was one dollar." Dr. Hamilton was the first president of the Geauga County Medical Society in 1866 and died the next year.

Dr. H. O. Blair had been president of the Homeopathic State Society from the start, and in 1864 he called a meeting at Columbus to form a new and permanent association. The State Society has been a bulwark of strength to the homeopaths. Their interests have been conserved and their rights safeguarded. The Society was incorporated in 1878. Since 1865 the transactions have been published annually. The State Society meets yearly in May. Since Huron Road Hospital is permanently established and is admirably suited to postgraduate teaching, it seems wise to hold the meetings there regularly in Cleveland. There is an outstanding

guest speaker and teacher each year for two days' postgraduate work presenting surgical and medical clinical cases and lectures at the State Society meeting. The seventy-fifth anniversary meeting was held in Cleveland in 1939 at the Statler Hotel under the presidency of Dr. Lucy Stone Hertzog. Dr. Garth Boericke, teacher of Materia Medica at Hahnemann College, Philadelphia, was one of the two postgraduate instructors, and the other was Dr. Walter Grey Crump, Sr., internationally known scientist, surgeon, author and teacher. The instruction of these two outstanding teachers plus the very fine regular convention program filled four never-to-be-forgotten days, which made of the seventy-fifth anniversary a truly gala occasion.

Among recent annual postgraduate instructors have been Dr. E. Wallace MacAdam, Dr. Lynn Boyd and Dr. T. H. MacGavack, all of New York, and Dr. W. W. Young and Dr. Garth Boericke of Philadelphia.

There have been scores of local homeopathic societies throughout the state which served a section at various times but most of them are gone. Cincinnati had one in the early days of a thousand members, mostly laymen. It petitioned the General Assembly of 1849 for an Act establishing a homeopathic college in both Cincinnati and Cleveland, and made its objectives.

The Homeopathic Lyceum functioned in Cincinnati for fifty years, and was abandoned for local reasons about 1940. The Cleveland Homeopathic Society has met monthly for many years.

It would require many pages to record the great number of valuable periodicals that have served a period or a section adequately during the century and are no more. "*The Bulletin*" which now serves homeopathic interests in Ohio is published in Cleveland under the auspices of the Cleveland and Ohio State Homeopathic Societies, and the Staff of Huron Road Hospital. It is concluding its sixteenth year and is an excellent publication.

Some years ago, Dr. W. J. Mayo said at a medical convention in his own state, "There has always been a place in organized medicine for minority voices, and may the day never come when they do not rule." The Regular School would logically object strenuously to the removal of the Homeopathic and Eclectic representatives on Ohio's State Examining Board, for if the present legal division of representatives is broken up, the cults will dash in, in full force. The Homeopathic School has two excellent representatives serving at present in their third terms, Dr. Wm. M. Hoyt of Hillsboro and Dr. T. H. George of Cleveland.

CLEVELAND HOMEOPATHIC MEDICAL COLLEGE

In time, the united Homeopathic Colleges in Cleveland suffered the pinch occasioned by the standardization of Medical Colleges, and money to make the changes needed for A. M. A. approval was not available. In 1911 Pulte Medical College of Cincinnati had been absorbed by the Cleveland College but kept its money in Cincinnati. An acceptance of the Cleveland-Pulte College by the Ohio State University to be conducted as a homeopathic college by the University was accomplished and details worked out by our able Dr. Tom McCann of Dayton, then on the State Examining Board, aided by his friend and patient, Charles Kettering, who gave his blessing and $400,000 for the establishment of a complete research laboratory at the University for the purpose of scientific provings and exhaustive study of homeopathic remedies.

The minutes of the O. S. U. Trustees of May, 1914, contain this resolution: "Resolved that the Board of Trustees of the O. S. U. pursuant to resolution adopted January 27, 1914, now declare that the time has arrived for the establishment of a College of Homeopathic Medicine in the University, and that the Board proceed to open the facilities for such instruction next September, 1914." This was done.

Under the capable management of Dr. Claude A. Burrett the college flourished. Homeopathy has been handicapped because the prejudiced, the open-minded and the strong believers, equally, needed information that required properly equipped research laboratories to prove scientifically each homeopathic remedy, to determine what potency or dilution of each was most efficacious and to furnish answers to oft repeated questions.

Quite a few remedies have been scientifically proved in laboratories by such men as Hinsdale at Ann Arbor, Bier in Germany, Boyd and McGavack in New York and some others.

One day a northern Ohio doctor asked, at a Trustees' Meeting of O. S. U. in 1922, "Why should there be two schools of medicine, any more than two schools of architecture or law?" Unfortunately there was no one there to answer him adequately—and this small beginning had tragic ending. The President of the Ohio State Homeopathic Medical Society, Dr. R. A. Buchanan, at the meeting in Akron in 1923 commented thus: "At our meeting in Columbus last May there was a small cloud on the horizon but they had been there before and been dissipated, and we had the assurance of our friends in Court that we would have enough votes on the Board of Trustees to protect us. When last we met we had a flourishing college in connection with O. S. U. with a research laboratory completed, or nearly so, in which we planned to carry out exhaustive studies to prove the scientific basis of Similia Similibus Curentur.

"A few of our members without consulting any one took it upon themselves to express the opinion that amalgamation was the proper thing,

and one or two of the University Trustees were influenced by these expressed opinions to such an extent that they cast their vote against us, with the result that the College of Homeopathy was discontinued. Three members of the Board of Trustees of the University together with President Thompson remained loyal to our cause and gave of their time and effort unstintedly to prevent the miscarriage that resulted in our removal from the campus."

The amalgamation program suggested two chairs of Homeopathy, Materia Medica and Therapeutics, and Practice in the School of Medicine and was to be without hospital facilities for clinical work or the use of the laboratory Mr. Kettering had provided. This was of course out of the question, so the college closed in 1922 and the money was returned to a skeleton college organized in Cleveland along with the records.

So, by a series of blunders, misunderstandings and no doubt, some prejudice, all scientific medicine suffered loss—which might have helped mankind and glorified Ohio and its University.

PIONEER OF MANY TRENDS IN MODERN MOVE

Homeopathy is not a cult. It is orthodox, not sectarian. May I tell you why, briefly. It represents in its law of similars the underlying principle of all cures, no matter in what school of medicine, or under what name they are achieved. The homeopath has access to all the latest developments in the broad field of medicine. But we have something we consider definitely more valuable, the basic law that "like cures like"—which has stood the test of clinical use for over 100 years. We have as tools possibly two hundred proved remedies which are rarely used by the dominant school—and they are prepared differently by scientific methods of dilution and potentization to those of any other school. Know what is curable, eliminate producing causes and give the indicated remedy —that one which matches most accurately its proved symptoms with those of the patient, and if prescribed on the same indications as in Hahnemann's time, will give the same result whether in 1800 or 1949, in Alaska or in Florida. As McGavack says, "The Materia Medica pura of the early Nineteenth Century can be as intelligently read by new students today as by a physician contemporary with its publication." The homeopath makes two diagnoses; that of the disease and that of the remedy.

One hundred and fifty years ago Hahnemann introduced three entirely new ideas which he had proved true in curing the sick by study and usage: (1) the minimum dose, (2) the single remedy, (3) the similar remedy. They have revolutionized modern medical thought. He was truly one hundred years ahead of his time.

Hahnemann considered that his discovery of the power inherent in the high dilution and potentization of a remedy was the greatest discovery of the age. The finer the drug substance is divided the greater is the release of atomic energy. His promotion of the law of similars and potentized small doses anticipated modern science over a century, for here are atomic energy and pure drug energy to prove it, along with a few other things to be mentioned.

It happens often that some "new" cure is discovered, which was first given to the world by the homeopaths. They have long been familiar with sulphur as a remedy for certain forms of rheumatism. Here is a quotation from the August, 1936, number of the *Current Medical Digest*, "Encouraged by the excellent results reported by Peck and Rosenthal, the author used snake venom in treating seven cases of Menorrhagia in which no organic lesion could be demonstrated. Moccasin venom (1:3000) was injected subcutaneously." The article is a condensation taken from "Experience with Snake Venom in Menorrhagia" by C. H. Watkins—proceedings of the staff meetings of the Mayo Clinic. The author might be surprised to know that snake venom has been used by the homeopaths for this very purpose in similar strength for the past 100 years. Bee venom has been used for arthritis in the same way and strength. The infinitesimal has come into its own.

In common use today is the principle laid down by Hahnemann over a hundred years ago that "the products of disease may be used for the prevention of disease and eventually for its eradication." His experiments proved the theory of immunity used today in serums and vaccines. No one can refute the power of the infinitesimal. They only accept it more and more.

One of our homeopathic scientists, Dr. Chal P. Bryant of Seattle, has recently visited the Physics and Physiology departments of seventeen universities, where he found a welcome and a consensus that the three concepts of Hahnemann—minimum dose, single remedy, and similar remedy—can be translated into modern physics as correct. Similia is a universal law of physics because it is an application of frequency of radiation. Every object so far as tested has its effect or radiation. All drugs register this effect; crude drugs with least intensity, and homeopathic high potency drugs register the greatest energy of all. Each disease has its own characteristic and specific wave frequency which can only be destroyed by the similar frequency (potency) operating in the opposite direction 180° out of phase (similia). There can be no controversy in the field of physics.

The present-day psychosomatic medicine is not a new approach in the healing art. Hahnemann's philosophy was based not only on the

reactions of man as a physical organism but as a spiritual, psychical being. The homeopath is trained to search early in a case for the cause of illness, the personal equation. Is it not reasonable that intense emotion such as jealousy, fear, anger, despair can change the blood chemistry, create organic pathology, and acute conditions which if untreated can eventuate in chronic disaster? The mental slant in our philosophy may cast the deciding vote as to the indicated remedy.

We find Hahnemann's impress upon the world of medicine most graphically emblazoned upon a multitude of institutions; colleges, hospitals, dispensaries, asylums, sanitariums, not only here but in Europe, India, Mexico, South America where Homeopathy is widely used. No other doctor, has so many beautiful monuments erected to his memory here and in foreign countries. In view of the facts, there seems no point in the attempt to erase the words Hahnemann or Homeopathy from colleges and hospitals. We are proud of the fact that modern medical research and experience is substantiating the law of Similia Similibus Curentur. We may well think of Hahnemann as the unacknowledged pioneer of the most important trends of modern medicine. Hahnemann has influenced all medicine probably more than any one man, without credit being given to him. It is rare to see his name mentioned among the great leaders and molders of medical thought, when it should be in its proper place in the history of medicine with Hippocrates, Galen, Paracelsus, Harvey, Pasteur, etc.

There is a gradual closing of the gap between the two major schools of medical thought. Tolerance shows growth. Medicine should be a unit in its desire to cure the sick. All schools are children of "Old Mother Medicine" who during thousands of years had many children. No one represents all truth. Medicine or its practice is not bound by any school. Its application is boundless, its ethics universal, and the opportunities for service to humanity are limitless.

Dr. Myra King Merrick and Associates, 1852-1949

Dr. Merrick received her medical degree from the Central Medical College in Rochester, New York, studying later with a Hydropathic Institute in New York City and in 1859 in New Haven, Connecticut, under a distinguished practitioner, Dr. Ives—all in an effort to acquire clinical experience otherwise denied women. She moved to Cleveland in 1852 and was the first woman to practice medicine in Cleveland and Ohio.

Dr. Merrick was the motive power of the Women's Medical College founded in Cleveland in 1866, which was merged with the Homeopathic Medical College in 1871 upon condition that women would be forever admitted. Dr. Merrick was Professor of Obstetrics and Diseases of Women and Children during the three years of the existence of this college in which period it graduated seventeen women. She was the first woman professor west of the Atlantic Seaboard. She was instrumental in raising the first $10,000 for Huron Road Hospital.

Dr. Merrick was the founder and president until her death in 1899, of the Women's and Children's Free Medical and Surgical Dispensary which was organized by the Pioneer Homeopathic women physicians of Cleveland in 1878. The Dispensary was organized to give worthy poor women an opportunity to receive medical service of their own sex, and to give medical women an opportunity to get clinical experience otherwise denied them. Dr. Martha M. Stone was secretary, and Dr. Kate Parsons, co-founder and worker with Dr. Merrick, was treasurer until her death in 1907. Dr. Parsons was the third woman to practice in Cleveland, and her splendid ability gave her a clientele amongst the wealthiest families in the city. She gave freely of her time and strength to the Dispensary as visiting physician and collected funds in its interest.

Resolutions adopted by her associates at Dr. Merrick's death pledged "to carry on this cherished work of hers, and secure its permanent establishment for the benefit of the coming century, as best we may," signed by Dr. Annette Winship, Dr. Emily Robinson, Dr. Louise Tolles, Dr. Elizabeth Murray, and Dr. Martha Canfield. In the Woman's Hospital on 102nd St. in Cleveland, we see the fruition of her work, which only two of those who signed the "Resolution" lived to see fulfilled—Dr. Martha Canfield who served as first president of the Woman's Hospital Association until her death in 1916, and Dr. Emily Robinson who served on the Board of Trustees from 1922 to the time of her death in 1939.

Other homeopathic women physicians also active in the Dispensary Society and in the founding of the Woman's Hospital were Dr. Alice Butler, Dr. Josephine Danforth Gilette, Dr. Clara Clendon, Dr. Eliza Merrick, worthy daughter-in-law of Dr. Myra Merrick, Dr. Gertrude Meck, Dr. Nina Stansbury, Dr. Mary White, Dr. Pauline Barton-Peeke, Dr. Adda Hedges Brady, Dr. Mary George, and Dr. Mabelle S. Gilbert.—Lucy S. Hertzog, M. D., Chardon, Ohio.

No. 43. J. B., aged 64, Franklin County. Case—Recent Hernia upon the right side. The diagnostic symptoms of the disease were illustrated upon this case with the remark that a radical cure might be effected by a well fitting and hard padded truss.—*Ohio State Journal*, Tuesday evening, Dec. 4, 1849.

Cancer Detection Clinic in Holmes County

HARRY A. DUNCAN, M. D.

EXPERIENCE with cancer cases has emphasized one deplorable fact, viz., at least 90 per cent of the cases present themselves too late to expect lasting cures. It is very often too late when the first symptom is noted by the patient. She usually takes three months to worry and think about it before consulting her physician. Then the doctor may take three months to come to a decision before acting.

As in almost every small community our community had noted that when the diagnosis of cancer was whispered about of some individual that person's life expectancy was but a few months.

All this in spite of the talk of doctors and the literature of cancer societies that thousands of victims could be saved if the trouble were discovered early.

An organization of women received permission from the Board of our local hospital to foster a cancer detection clinic.

On January 24, 1946, the first clinic was held. Our plan was to make a complete physical examination of each patient and when indicated do a cystoscopic, proctoscopic examination and biopsies.

We were given an examining room, with adjoining dressing room and toilet. Our equipment included proper lights, sterilizer, instruments and cabinet, dressing tables, a filing case—all in charge of a graduate nurse.

On October 24, 1946, a committee from The American Cancer Society visited us and made the local society a chapter of The American Cancer Society with the approval of the County Medical Society.

No salaries are paid. No charge is made for the service. No report is made to the patient but a letter is sent to the family physician enumerating our findings including any non-malignant pathology found. No treatment is given. That is left to the family physician.

Patients are encouraged to return for re-examination once a year or every six months depending on the pathology found. During the years 1946, 1947 and 1948, 854 patients were examined; 663 were new patients and 191 re-visits.

During those three years we reported to the family doctors the following findings:

4 Breast Carcinomas
1 Ovarian Carcinoma
2 Cervical (Uterine) Carcinomas
1 Prostatic Cancer
1 Thyroid Cancer
2 Bowel Cancers
1 Pigmented Skin Sarcoma with Metastasis
1 Sarcoma of the Leg
14 Skin Epitheliomata
557 Non Malignant Pathological Conditions.

Many patients, especially gynecological, exhibited several pathological conditions.

Since January 1, 1949, we have taken smears from surface lesions and from every cervix uteri and subjected them to the Papanicolaou staining and microscopic study.

Up to this date we have studied smears from 295 cervices. It must be remembered that these patients were without any complaint suggesting malignancy.

One carcinoma proven by biopsy was found. Two other patients revealed cells suspicious of malignancy—one refused biopsy and the second one died suddenly before a biopsy could be done. Twenty-one exhibited atypical cells, many along with red blood cells, leukocytes or trichomonas. Many of these are doubtless inflammatory but they were asked to return for a recheck in three months. Two hundred seventy-one were negative for cancer.

Sunshine Can Produce Hives

Hives due to allergic reaction to sunlight is a rare condition. Interestingly enough, the condition may be transferred by injecting some of the patient's blood serum into the skin of a normal individual. The newer anti-allergy drugs help some. It is urged that contributing factors, notably pressure, be controlled while the patient is under treatment. The ordinary protective creams which are effective against sun-burn are not effective because they do not protect against the longer ultra-violet rays.—Stephen Epstein, M. D., Marshfield, Wisconsin, Annals of Allergy, July-August, 1949.

That older persons now constitute the major focus of tuberculous infection is emphasized by recent autopsy studies which show that a relatively large number of persons supposedly succumbing to diseases other than tuberculosis were found to have this disease in active form. It is recognized that the disease in older persons is frequently mild and that the symptoms may be overlooked.—Statistical Bull., Metropolitan Insurance Co., Nov., 1948.

Income and Other Taxes . . .

Physicians Are Advised To Exercise Utmost Care in Filing Numerous Required Returns; Federal and State Tax Requirements Summarized

WITH the end of the year approaching, physicians are again advised that the utmost care should be exercised in filing income tax returns and other tax reports required by Federal, State and local laws. The following summary of tax requirements is published—not as a final authority, but in the hope that it will help physicians in the complicated procedure of filing required returns.

Most physicians are in the category of persons who must file returns on (1) Federal Income Tax; (2) Federal Social Security—(a) Old Age and Survivors' Insurance Tax and (b) Unemployment Insurance Tax; (3) Ohio Unemployment Compensation Tax; (4) Ohio Personal Property Tax; (5) Ohio Use Tax; and (6) Ohio Workmen's Compensation Tax. Obligations of the taxpayer in regard to laws governing each of the foregoing are summarized in succeeding paragraphs.

The accompanying information in regard to Federal income taxes is based on material supplied to The Journal by Mr. S. F. Noggle, Columbus, for many years chief of Income Tax for the 11th Ohio Internal Revenue District. Every effort has been made to keep it as authentic as possible within the limits of brevity. Physicians are advised, nevertheless, to obtain advice and assistance in the preparation of their returns from competent legal or tax authorities or from staff members of the office of District Collectors of Internal Revenue.

INCOME TAX ACT OF 1948

Virtually no changes have been made in the Federal income tax requirements since last year. The Revenue Act of 1948 effected a number of changes in the Federal income tax structure. These changes, however, were effective as of the 1948 tax year and were taken into consideration with the filing of last year's returns. Previous articles on this subject in *The Journal* have warned that the Treasury Department seems to be placing more strict interpretations on many provisions of existing laws.

The income-splitting provision of the Act of 1948 in effect places individuals in non-community property states (like Ohio) on the same basis for income tax purposes as those living in community-property states. That is, a husband and wife in many cases may effect substantial reductions by splitting their income on a joint return. On such a joint return, the taxable income (adjusted gross income less optional standard or ordinary deductions and less exemption credits) is then divided in half and a tentative tax computed on half of the income.

In addition to the reduction in rates because of the computation being made only on half the income, credits are provided after arriving at the amount of the tentative tax. There is to be deducted 17 per cent of the first $400 of such tentative tax, or $68. If the tax is in excess of $400, the deduction will be $68 plus 12 per cent of the amount in excess of $400. The net tentative tax is then multiplied by two to arrive at the total tax liability.

There are exceptional cases in which the income-splitting provisions may not work to the advantage of the couple. Each case must be considered on its own contingencies.

PERSONAL EXEMPTIONS AND CREDIT FOR DEPENDENTS

The personal exemption is $600 for the taxpayer and $600 for his spouse. An additional exemption of $600 is allowable for each spouse who has reached the age of 65. For each spouse who is blind, an additional $600 may be claimed.

An exemption of $600 may be claimed for each dependent of close relationship. To claim dependency, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. A dependent cannot have a gross income of $500 or more for the taxable year.

FORMS AND PAYMENTS

Every person whose gross income for 1949 was $600 or more must file certain income tax returns with the Collector of Internal Revenue for his district, not later than March 15, 1950.

Every physician who comes within the provisions of the Income Tax Law must do the following:

1. File a complete income tax return for 1949. He should use Form 1040, either the short form or the long form. The short form may be used only when the adjusted gross income is less than $5,000 and when the tax is taken from the table. The long form must be used when

the income is $5,000 or more or when the taxpayer wishes to claim credit for non-business deductions, such as charitable contributions, personal interest or taxes.

2. Pay the difference, if any, between the income tax paid during 1949, based on the estimated return for 1949 which he filed during that year and the amount of the tax computed on his final return for 1949 filed on or before March 15, 1950. If he has overpaid, the excess amount will be refunded or credited against future tax payments. Amounts refunded carry interest at six per cent from March 15, 1950, to date of payment.

3. File a declaration of estimated tax for the year 1950, and pay one fourth of the estimated tax for 1950, the balance payable quarterly thereafter. Blanks for filing the 1950 return will be mailed to taxpayers of record by the district collectors of internal revenue. If estimated returns for 1950 are based on 1949 income and the tax computed at the 1950 rates, no penalty will be assessed even though the estimated tax is understated by more than 20 per cent.

REPORT ON FUNDS PAID

While it is necessary this year to report salaries of office assistants and other employees whose salaries are subject to the withholding tax, as in previous years payments in excess of $500 made during 1949 for interest, rents or commissions, not subject to withholding and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15, 1950, to the Commissioner of Internal Revenue, Processing Division, Kansas City, Mo.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Collector of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue, Federal Building, Water and Gay Sts., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue, 262 Federal Building, Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue, Customs Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

ADJUSTED GROSS INCOME

Individuals who are employed and receive a salary have no difficulty in arriving at the amount of their adjusted gross income. The total salary received plus any amounts which might be received from interest or dividends would in such cases constitute the gross income.

The physician has more difficulty in arriving at his adjusted gross income. From the amount of his cash receipts—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections.

DEDUCTIBLE BUSINESS EXPENSES

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he cannot claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician possesses two cars, each of which is used partly in pro-

fessional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held not to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in attending medical conventions for a professional purpose are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicines, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purposes) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as ordinary deductions only. All license fees which the physician is required to pay, including narcotic tax and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as an ordinary deduction only. The tax paid on telephone bills, if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills would be deductible only as an ordinary deduction. Federal taxes on amusements, club dues, furs and luxuries are not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for in-

surance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are ordinary deductions and not to be taken as business expenses.

Ohio Gasoline Tax—This tax is deductible to the extent of four cents per gallon. However, if a physician has already included cost of gasoline as part of his business expenses, the tax is not again deductible. The tax paid on gasoline not used in business is deductible as an ordinary deduction.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as ordinary deductions. Interest paid to carry tax free securities may not be deducted.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible.

ORDINARY DEDUCTIONS

In addition to items mentioned in the foregoing paragraphs which would not fall under the category of ordinary deductions, the following may be taken under that heading:

Contributions, Gifts, Etc.—It is permissible to deduct from gross income, contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an aggregate amount not to exceed 15 per cent of the adjusted gross income.

Optional Standard Deductions—The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes and other ordinary deductions, has under the provisions of the Revenue Act of 1948 been increased. Under the old law, the maximum standard deduction was $500. Under the new act, the optional standard deduction is 10 per cent of the adjusted gross income, but not in excess of $1,000.

Medical and Dental Expenses—Deduction is permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of five per cent of the adjusted gross income. In the case of a husband and wife filing a joint return, the expenses are not deductible unless they exceed five per cent of the aggregate adjusted gross income of both. The maximum allowable deduction on a joint return is $2,500 plus $1,250 for each dependent listed on the return, not to exceed two. The maximum deduction is $5,000. The maximum allowed for a single person with no dependents is $1,250. The term "medical care" as used in the act, is broadly defined to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accidents or health insurance)."

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

CHANGE IN WITHHOLDING ROUTINE

Effective January 1, 1950, a change in withholding tax routine will become effective. Heretofore employers who accumulated as much as $100 for the purposes of income tax liability of employees have taken these funds to the bank and purchased a depositary receipt which they attached to the quarterly Form W-1 in lieu of cash. Under the new routine the employer will proceed as in the past except that instead of receiving his depositary receipt immediately from the bank, the bank will send it to the Federal Reserve Bank in Cleveland for validation, after which it will be returned directly to the employer. Not until then is the depositary receipt, which will be known as Form 450, eligible for use.

FEDERAL OLD AGE BENEFITS TAX

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance.

The Old Age and Survivors' Insurance Tax is

payable by every physician who employs one or more persons in his office. An increase in the rate of payment becomes effective January 1, 1950. Through 1949, the employer was required to contribute one per cent on the first $3,000 of each employee's wage, and deduct a like amount from the wages of each employee. Effective the first year, the contribution will be one-and-one-half per cent in each case. The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed prior to April 30, 1950, for the months of January, February and March, 1950, in the office of the District Collector of Internal Revenue, and quarterly thereafter, payable the month after the quarter ends.

FEDERAL UNEMPLOYMENT TAX

This tax is payable to the Collector of Internal Revenue by January 31 for the previous year. It applies only to employers who have had eight or more persons on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. The tax is three per cent on all individual wages up to $3,000. A credit of 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO UNEMPLOYMENT COMPENSATION TAX

In general, employment of three or more persons in any one day renders the employer liable for this tax. There are certain exceptions. A physician who is in doubt as to his liability, therefore, should request clarification from the Bureau of Unemployment Compensation, Columbus.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually according to a table in the law which is based on the ratio the tax paid by the employer bears to the benefits paid to his former employees and chargeable to the employment the claimants had with the employer. This rate starts at 2.7 per cent and may be reduced to as low as three-tenths of one per cent. Only the first $3,000 earned by any individual in a calendar year is taxable.

OHIO WORKMEN'S COMPENSATION LAW

Every employer of three or more employees is required under the Workmen's Compensation Law of Ohio to file during the month of January a statement containing the following information: The number of employees employed during the preceding year, the number of such employees employed at each kind of employment and the aggregate amount of wages paid to such employees. The employer must pay into the fund a premium based upon occupational hazard of the job in which the employee is engaged. An employer of less than three persons, although not obligated to do so, may elect to pay premiums into the funds on employees.

OHIO SALES AND USE TAX

Section 5546-2 of the General Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department. However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15, 1950, for purchases, during the period January 1 to March 31, 1950, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Rule 102 of the Ohio Tax Commissioner applies specifically to physicians and dentists. It reads: "Physicians and dentists are the consumers of the various items of tangible personal property which they use in the rendition of their professional services and the tax

Keeping Records

Entries on the following categories of professional expenses should be made in order to complete records for income tax purposes, according to Stanley R. Mauck, director of the Columbus Bureau of Medical Economics: Drugs and professional supplies; salaries and fees to assistants; utilities (heat, light and telephone), printing; postage and office supplies; interest, taxes and insurance on business property; dues and subscriptions to professional societies and publications; rents and repairs; auto and transportation expense; miscellaneous (such as laundry charges, etc.)

will apply upon their purchase of all items of tangible personal property, including equipment. The tax does not apply to the fee for professional services rendered by physicians and dentists. If physicians and dentists apart from their professional services and engaged in selling, to the public such articles as medical supplies, mouth washes, dentifrices and the like, they are vendors and must procure a vendor's license and collect the tax on all such sales."

OHIO PERSONAL PROPERTY TAX

There have been no fundamental changes in the Ohio Personal Property Tax provisions.

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31 annually. One half the amount of the tax is paid when the return is filed, and the other half is due September 20.

The State Tax Commissioner is currently conducting a campaign to increase efficiency in the collection of this tax, and penalties are being assessed against those who have been delinquent or have failed to declare personal property for taxation.

All intangible personal property in possession of a physician on January 1, 1950, and tangible personal property (not real estate) used by him in his business, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates. Form 910 is used by individuals and partnerships, and Form 930 by corporations.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies, etc.

Such returns should be made in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5389 of the General Code.

As defined in Section 5327 of the law, credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50% 25%, 10%, etc., of its full face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1949 return he would be permitted to return as of "no value" accounts receivable which he listed in 1948 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1948 but which have decreased in actual value during the past year.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since October 2, 1949. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY
- Charles A. Barnes, Cleveland
- Milton Brotman, Cleveland
- Louis D. Chapin, Cleveland
- Henry H. Fertig, Cleveland
- Jack B. Horrocks, Cleveland
- William L. Huffman, Cleveland
- Paul D. Jones, Cleveland
- Max L. Kirk, Euclid
- Edward Prince McCreery, Jr., Cleveland
- William A. Morningstar, Cleveland
- Nicholas K. Ronan, Cleveland
- Hugo Rosenthal, Euclid
- John H. Sanders, Cleveland
- Marvin H. Sobel, Cleveland
- Paul P. Superfisky, Cleveland
- Abraham Unger, Cleveland
- Robert E. Wise, Cleveland

FRANKLIN COUNTY
- Charles H. Hendricks, Columbus
- Joseph Kosar, Columbus
- Milton Levitin, Columbus
- Frederick A. Waltz, Columbus

HAMILTON COUNTY
- Victor R. Case, Cincinnati
- George T. Critz, Lt. j.g., Chelsea, Mass.
- Omer J. Feldhaus, Reading
- Robert W. Kistner, Cincinnati
- Joseph A. Lane, Cincinnati
- Richard H. Tapke, Cincinnati
- Albert E. Thielen, Cincinnati
- Richard N. Westcott, Cincinnati
- Paul B. Winston, Norwood

LORAIN COUNTY
- Conrad T. Rusin, Lorain

LUCAS COUNTY
- Joseph P. Moran, Toledo
- James H. Pollex, Toledo
- Joseph B. Westhoven, Toledo

MEDINA COUNTY
- Otis G. Austin, Medina
- Andrew J. Karson, Medina

MUSKINGUM COUNTY
- Louis Berman, Zanesville

RICHLAND COUNTY
- Robert E. Moffatt, Mansfield

STARK COUNTY
- Lee C. Underwood, Canton
- William A. White, Jr. Canton

SUMMIT COUNTY
- Wendell E. James, Akron
- Carl T. Korsmo, Akron

WYANDOT COUNTY
- Thomas A. Ferguson, Upper Sandusky
- Raymond J. Murphy, Carey

What Will Congress Do in 1950?...

Straws-in-the-Wind and Trends on Compulsory Sickness Insurance Issue Reviewed; Odds Appear Against Enactment Now; Election Vital

WHAT are the prospects for or against enactment of compulsory sickness insurance legislation by the 81st Congress when it re-convenes next January?

Obviously, no one can answer that question with any degree of certainty. Nevertheless, there are some straws in the wind which should be kept in mind by physicians—and others—who are aware of the fact that health insurance has become a political issue and that the people are giving more attention to this question today than ever before.

President Truman, Social Security Administrator Ewing, and other headliners among the proponents of a compulsory sickness insurance program have not retreated from their original stand that the nation must have such a program. This view is supported by recent speeches which they have made and by statements made to the press on this question. Therefore, there appears to be little doubt but what they will continue to plug for compulsory health insurance legislation during the next session of the Congress—openly, at least, and for headline consumption.

COMPROMISES IN PROSPECT

There are some observers who predict that the administration may find it expedient to go for a compromise in the hope of being able to build up some kind of a record for public consumption during the 1950 Congressional elections.

Some believe that this compromise might be in the form of legislation which would expand the facilities for the education of physicians and other health personnel; enlarge public health services and facilities; provide Federal aid for school health services; and increase Federal participation in other health-welfare programs, through the Social Security System and elsewhere.

Other compromises mentioned include a program of insurance which would cover hospital care only; one for medical care for "catastrophic" illnesses; or, perhaps, one setting up Federal aid which could be used to provide coverage in voluntary hospital and medical care plans for those unable to provide such coverage for themselves.

Most of the correspondents who have made a careful survey of the present Congress on this matter are of the opinion that the chances for enactment of compulsory sickness insurance by the 81st Congress are just about nil.

Three reasons for making this prediction are: (1) The majority of the members of the 81st Congress are not at the moment sold on the idea of a compulsory plan; (2) the public's attitude on the issue has not crystallized as yet; (3) efforts will be made to avoid serious controversies in 1950 so Congress can adjourn reasonably early, to permit members running for re-election to begin their campaigns.

These same correspondents admit, however, that the prospects are fairly good for enactment of some of the piece-meal legislation now in the hopper but less controversial in character. They point out that many members of Congress are of the opinion that the Federal Government must provide some additional assistance, or new assistance, in some of the health and medical fields where needs have been proven. Also, they believe that health legislation which would not be objectionable to any large segment of the voters would be good re-election ammunition for Congressmen who are staking their future on the outcome of the 1950 elections.

CONGRESSMEN SCRUTINIZE PLANS

Many members of the present Congress are giving careful scrutiny to the British health insurance program and to the one in operation in Sweden. The data assembled on these plans for their study may have an important bearing on how members will re-act when the Truman proposal is brought forth for a show-down—if it is—in 1950.

As pointed out in an article in the November issue of *The Journal*, page 1096, the majority of the Congressmen who visited England and Sweden during the past Summer are dubious about the plans in those countries and feel that they do not in any way provide the solutions for existing problems in the United States.

SEE 'GOOD' IN BRITISH PLAN

On the other hand, a few members of Congress who have seen the British plan in action are of the opinion that it has good points and that action for setting up some kind of a national health program here should not be delayed.

Such an attitude was expressed recently by Congressman Robert Crosser, Cleveland, in a newspaper interview after his return from Europe. Crosser is chairman of the House Committee on Interstate and Foreign Commerce

which has the compulsory sickness insurance bills under consideration.

Following is a Washington dateline story by Fletcher Knebel, *Cleveland Plain Dealer* correspondent, based on an interview with the veteran Ohio Congressman:

> Representative Robert Crosser, veteran Cleveland Democrat, tonight predicted his House commerce committee will approve some type of national health program early next year.
>
> Crosser declared that the British inspection "tempered" committee opposition to national health insurance which failed to get a green light in this session of Congress.
>
> **"I don't say a national health bill will be approved," he said, "but my guess is the committee will report that type of legislation for floor action."**
>
> Crosser will report the committee's new feelings and findings to President Truman, whose demand for compulsory health insurance has stirred a violent controversy.
>
> The report should cheer the president, for Crosser said that while bitter foes and ardent champions of health insurance had not changed their views, the whole committee's feeling of "hostility" had been "modified" by the British visit.
>
> **Crosser still declines to commit himself on compulsory health insurance, but he now appears ready to consider the administration's bill with what he calls a "cautious" approach.**
>
> "The big question in my mind," he said, "was whether the British government's health plan limits the freedom of physicians. I put that question repeatedly to doctors.
>
> "Most of them told me that, on the contrary, their freedom of dealing with patients had been enhanced, since they can now prescribe treatments for all persons on the basis of need, not cost.
>
> "Previously, they could not give certain drugs and treatments to a patient because of his inability to pay for them."
>
> Crosser said British doctors objected to abuses of the government-financed system, but not to the basic plan. They would not "abolish" it, but "change" it, he added.
>
> "Most of them think there should be regulations against taking physicians' time with little Johnny's sniffles. They also think more doctors are needed and that the average of 4,000 persons to each physician should be decreased."
>
> The commerce committee chairman said he believed Congress should avoid the British mistake "of trying to do too much all at once."
>
> The Cleveland legislator said the committee was impressed with "the frank and honest" presentation of the British program by Minister of Health Aneurin Bevan. He expressed belief that Bevan made no effort to hide the errors and pitfalls in the British system.
>
> "We tried to hear both sides," he said, "and I'm sure the committee clarified many of its misunderstandings of Britain's program."
>
> Crosser said he did not think that the views of Representative Wilson D. Gillette (R.-Pa.), who returned to warn that adoption of the British plan here would bankrupt the country, were representative of the whole committee.
>
> The commerce chairman said he will resist any effort by bitter-end foes of health insurance to stall for more time.
>
> **"At the first meeting in January," he said, "I'm going to ask for a vote on considering the health bills before us. We've had enough hearings and gathered all the information we need. The question now is whether we drop health insurance legislation entirely or prepare to report legislation to the House."**

1950 IS ELECTION YEAR

Support for those who predict that Congress will keep its hands off compulsory health insurance legislation during 1950 came from unexpected quarters recently when U. S. Senator Hubert H. Humphrey, Minnesota Democrat, who has been an ardent proponent of the Truman-Ewing-Murray proposals and is a member of the Senate Labor and Welfare Committee issued a formal statement advocating that Congress delay action on these measures, pending further study and enactment of other "related" health bills.

NOTHING FINAL IN 1950

Following is an article issued by the Associated Press on Humphrey's statement, the content of which is confirmed by comments made by other correspondents after digesting the Senator's statement:

> Sen. Humphrey (D.-Minn.), a sponsor of President Truman's national health insurance program, said tonight that Congress must defer action on it pending further study and until enactment of related health measures.
>
> The Minnesota lawmaker said he always believed in the social security principle of the proposed insurance program. But he added that until the "practical difficulties" of administering the hotly disputed plan have been met, "legislative action might well be a disservice to the principle in which we believe."
>
> **Humphrey indicated he expects no final congressional action on the bill next year. He thus lined up with two other sponsors of the measure who look for it to stay on the shelf through 1950. They are Sens. Elbert D. Thomas (D.-Utah) and Murray (D.-Mont.).**
>
> Humphrey set forth his views in a statement which is known to have been prompted by reports he was withdrawing his support from Mr. Truman's health insurance program. He said:
>
> **"In establishing such a national program we do not have any previous state experience or experiments from which to learn and on which to base the administration of such a program. Since problems of administration are often formidable barriers to effectively carry out valid objectives, I believe it is vital that those of us who recognize the**

need of comprehensive health insurance prepare ourselves to solve the administrative problems of any such legislation.

"It is my considered judgment, therefore, that legislation for health insurance is not yet in the legislative action state and will not be in that stage, regardless of its merits, until there have been further hearings, further research, and until a basic administrative formula has been developed."

Humphrey said that for those reasons, and "in view of the great need not now being met by existing voluntary plans, I urge upon the medical profession and the consumer the improvement of voluntary health plans, the extension of co-operative medicine, group health programs and the development of health services for industrial workers through collective bargaining."

MAY SPLIT ON HIGH PRESSURE

Some observers point to the statements issued by Crosser and Humphrey as evidence of a split in the ranks of those who have been regarded as sympathetic to the Truman-Ewing idea of high-pressuring Congress into action before the 1950 elections. Some have intimated that Humphrey may have had his tongue in his check when he issued the statement; that it was intended to disarm those who are opposing compulsory health insurance legislation. However, those who are close to the Minnesota Senator are of the opinion that he is sincere in his present attitude opposing hasty action. Also, they point out that some of organized labor's spokesmen have severely criticized Humphrey for his action, despite the fact that he is regarded in Washington as one of labor's foremost champions.

LABOR IN DILEMMA

So far as labor is concerned, there are no surface indications that it has changed its mind in demanding immediate enactment of the Truman Health Program. However, some who have access to information from behind the scenes believe that labor leaders find themselves on the horns of a dilemma.

They point out that labor leaders realize enactment of the Truman program would place the administrative authority in the hands of political bureaucrats. On the other hand, voluntary medical plans which might be agreed upon between labor and industry through collective bargaining would place administrative authority in the hands of the managing boards of such plans on which labor might request, and expect, representation. It is concluded, therefore, that the success which labor has had in having medical and hospital care coverage inserted in working contracts with many industries may slow up the demands of labor's big brass for Congressional action on compulsory sickness insurance.

Those who have been pointing their finger at the Scandinavian countries as having so-called "model" health programs which should be duplicated by the United States, in all probability got a jolt from the recent report of Marquis Childs, Scripps-Howard columnist, dispatched under a Stockholm, Sweden, dateline. Childs, whose liberal views are well known, intimates that the contrast between Sweden and the United States is so marked that this country should not assume that what has worked there also will be a success in this country. His report from Sweden read in part as follows:

> The stream of students, professors, congressmen and just plain citizens who come here to look into Sweden's elaborate system of social reform are almost all impressed by at least one fact. That is the lengthy experimentation and study that have preceded most of the reforms making up the Swedish welfare program.

SYSTEM 'PUSHED THROUGH'

> The government recently pushed through a compulsory health insurance system which will go into effect in 1951. But this step was taken against a background of voluntary health insurance and state-supported medicine that goes back 300 years.
>
> Voluntary insurance societies, supported by government subsidies, had developed so that they included more than 60 per cent of the population in a single government-sponsored system. This was not, however, considered adequate since it did not cover the lower-income groups.
>
> What the new law has done is to expand the voluntary system to cover the whole population. About $5 a year will be added to each taxpayer's tax bill for health insurance and this will meet about a third of the cost. The balance will come out of general tax revenue.
>
> While there was strong opposition to making the system compulsory, especially from the doctors, the decision was not taken entirely on party lines. Even some conservatives recognized that a drastic step was necessary to raise the level of medical care. The number of doctors in proportion to the population is considerably lower here than it is in America.
>
> For many years children in all Swedish schools have received free medical examinations and a large measure of free medical care. This has been true both in the city and the country.

HOSPITALS LONG SUBSIDIZED

> Hospital care has long been subsidized by municipalities, counties and to some extent by the central government. At Stockholm's handsome new 1200-bed hospital the patient pays about 80 cents a day and this covers medicine, X-ray, everything. The actual cost is $5.60 a day and the difference is made up by the public subsidy.
>
> Likewise in Norway a voluntary health insurance plan in force since 1911 has gradually evolved to cover an ever greater number of persons. Now it is to be extended

to cover the whole population. In Norway the individual pays six-elevenths of the cost of the scheme, the employer two-elevenths, the municipality one-eleventh and the central government two-elevenths.

The contrast with the United States doesn't need much pointing up. Because of the persistent and prolonged opposition to voluntary health insurance, we have had very little experience in this field. That means it would be all the more difficult in America, with its wide differences of geography and custom, to impose a uniform compulsory system.

In Scandinavia they have learned through experimentation something that the British are discovering in the most costly fashion. To give drugs entirely free under a health insurance system is to risk bankrupting the system. They tried it in Norway and the cost skyrocketed.

Similarly, experience here has indicated that you are asking too much of human nature if you have the service of the doctor entirely free. Experience has shown if the individual pays half of the cost of the first visit to a doctor and perhaps a fraction of the cost of the second and third visits, there will be fewer abuses.

In Norway they have tried to preserve the doctor-patient relationship within the impersonality of an insurance scheme. Thus the patient selects his own physician and pays the doctor the fee. He is later reimbursed by the insurance system.

CALCULATED SOCIAL POLICY

Reforms here in this northern welfare zone often seem radical, but they can almost always be traced to carefully calculated social policy. Every mother in Sweden is paid $50 a year for every child under 16 years of age. Most mothers and children are given vacation allowances by the state. Such laws have their origin in the fact that before the war Sweden's birth rate was declining so rapidly there would soon be too few people to carry on in a country of this size.

Most of the opposition is on the score of cost, and that is particularly true, as in America, of the compulsory health insurance plan. The powerful employers' organization charged that the government had failed to make anything like an accurate calculation of the cost of the scheme. But here they can at least come closer to knowing the cost, since for so long they have been experimenting with ways and means for curing the ills that beset human society.

SUMMARY

To summarize: What Congress will do in 1950 appears at the moment to be anybody's guess. The odds appear to be against enactment of compulsory sickness insurance. The chances for enactment of some of the measures referred to by Senator Humphrey look to be 50-50, or slightly better.

There is one point, however, on which there seems to be no difference of opinion among all who have studied the facts and trends, namely: The ultimate decision on compulsory sickness insurance will depend for the most part on the attitude of the public by the time of the Congressional elections in November, 1950, and on the kind of men and women elected to the 82nd Congress. For this reason, some have labeled 1950 as the year of decision—at least the year of decision on the issue of compulsory sickness insurance.

Western Reserve Medical School Seeks Additional Endowments

The expense of the Western Reserve University School of Medicine will exceed anticipated income by $317,000 during the 1950-51 year, according to a statement issued by The Joint Committee For the Advancement of Medical Education and Research, which is composed of representatives of the public, the University, and affiliated hospitals.

Addressed to "All Greater Cleveland Residents," the brochure enumerates the benefits which the community derives from the School of Medicine and explains why additional financial support is necessary.

A message over the signature of George M. Humphrey, chairman of the committee, and president of the M. A. Hanna Company, suggests that a tax-deductible bequest can be made at a relatively small cost, and thus the benefactor can help provide better medical care for himself and family in the future, and share in bringing great benefit to the entire community.

Statistics furnished indicate that cost per student next year will be $3,237, while tuition per student is $800. The school will have an enrollment of 325.

Opinion of Attorney General

The Syllabus of Opinion No. 940, recently rendered by Attorney General Herbert S. Duffy, reads as follows:

"The Division of Aid for the Aged may not permit the Industrial Commission to examine the file of an old age recipient to determine whether the medical data there is consistent with that placed on file in the claim for workmen's compensation in view of the provisions of Section 1359-24a, General Code, which limit disclosure of such information to purposes directly connected with the administration of aid for the aged or other forms of public assistance."

Paul V. Brown, superintendent of schools at Tiffin, was named president of the Ohio Society for Crippled Children, the Easter Seal Agency, at the organization's annual convention in Columbus.

It's Time To Be Thinking . . .

About

Hotel Reservations

for the

1950 Annual Meeting



Ohio State Medical Association

Cleveland, Ohio . . . May 16, 17, 18

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
ALLERTON HOTEL, 1802 E. 13th St.	$3.50-6.50 $2.50 RW	$5.50-10.00	$6.00-10.00 $4.00 RW
AUDITORIUM HOTEL, 1315 E. Sixth St.	$3.50-3.75 $4.50-5.00	$5.50-6.00 $7.00	$7.50 and Up
CARTER HOTEL, PUBLIC SQUARE	$4.75-7.00	$7.00-10.00	$8.00-12.00
CLEVELAND HOTEL (Headquarters Hotel)	$4.50	$6.50-9.00	$9.00-14.00
HOLLENDEN HOTEL, 610 Superior Ave.	$3.50-8.00	$5.50-10.00	$7.00-14.00
OLMSTEAD HOTEL, Superior & E. Ninth	$3.00-6.00	$5.00-8.00 $7.00-9.50	$7.00-9.50
STATLER HOTEL, Euclid at E. 12th St.	$4.00-6.00	$7.00-10.00	$8.00-12.00

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Hotel, Cleveland, Ohio

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 16, 17, 18, 1950, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Suite

Arriving May.....at .....A. M. ..... P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

FIRST CALL FOR ENTRIES IN

Scientific and Educational Exhibit

1950 Annual Meeting, Ohio State Medical Association
May 16-18, Cleveland Public Auditorium

ONE of the outstanding features of the 1950 Annual Meeting of the Ohio State Medical Association, May 16-18, Cleveland Public Auditorium, will be the SCIENTIFIC AND EDUCATIONAL EXHIBIT. The exhibit held in connection with the 1949 meeting in Columbus was highly praised by members attending the meeting. Efforts will be made to make the 1950 exhibit even bigger and better than the one in 1949 and in previous years.

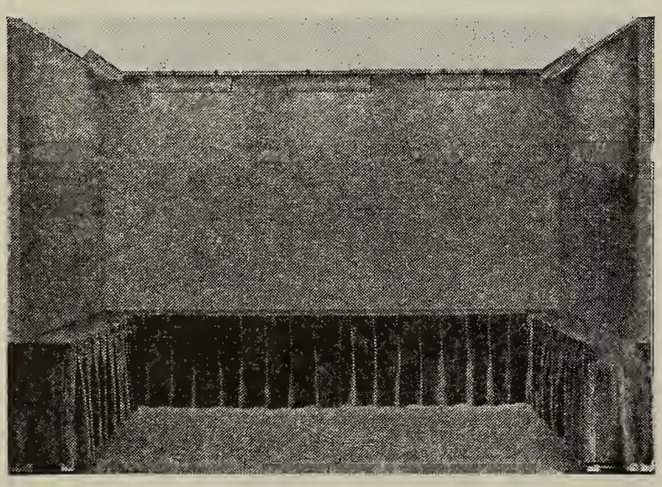
This is a general invitation to members of the Ohio State Medical Association to participate, as well as others who have display material which will be of scientific value and of general educational value to physicians.

Please note: Exhibit material does not have to be strictly scientific. If it presents data which will be of general educational value to the medical profession, it will be considered by the committee which has full authority to accept or reject applications at its own direction.

On the opposite page will be found an application blank. If you have material suitable for an exhibit, or know of some colleague or group of physicians having interesting material to display, send in an application and suggest to others that they do so.

The Scientific and Educational Exhibit will be in the same hall with the Technical Exhibit. This will be a grand break for both exhibits.

The firm which handles exhibits for the American Medical Association and handled exhibits for the 1949 O. S. M. A. meeting—Advertising Displays and Decorations, Cleveland—will supply the equipment and supervise the erection of the exhibit. Equipment and facilities similar to that used at A. M. A. meetings will be used. **The accompanying picture shows the type of booth which will be provided.**



Type of Booth To Be Used for Scientific Exhibits

Booths will be of uniform color and design; solidly constructed of wood and wallboard; skirted with velour. There will be a shelf. The upper area will be covered with taut blue crash fabric for bulletin board background and will permit the tacking or taping of charts and specimens without fear of damaging the exhibits. Fluorescent lights are a part of the background.

APPLICATION

For Space in the Scientific and Educational Exhibit

1950 Annual Meeting • Ohio State Medical Association

CLEVELAND PUBLIC AUDITORIUM CLEVELAND, OHIO MAY 16-18, 1950

Fill Out and Mail to:

CHARLES L. HUDSON, M. D., *Chairman*
Committee on Scientific and Educational Exhibits
2102 Abington Rd., Cleveland, Ohio

---

1. Title of Exhibit: _____

2. Description or nature of exhibit: (attach 200-word description to this blank).

3. Will radiologic viewing boxes be needed? If so, state number and size:

   Number of boxes needed_____ Size required_____
   (Please indicate if you plan to furnish own view box.)

4. Will you require shelf space? If so, how much? _____

5. How much floor space will you require? _____

6. How much back wall space will you require? _____

7. How much side wall space will you require? _____

8. Other material or equipment required: _____

9. Name of exhibitor: _____

   _____ (Street) _____ (City)

10. Name of institution cooperating in exhibit (if desired):

    _____

    _____

Cost of transporting exhibits to the meeting must be borne by individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

Federal Hospital Aid Doubled . . .

Ohio Will Receive Boost to Nearly Six Million Dollars Per Year Grant-in-Aid Toward Construction; 29 Projects Previously Approved

AMENDMENTS to Public Law 725 (Hill-Burton Law) enacted by Congress this year, virtually doubled Federal grants-in-aid for hospital construction in Ohio and extended the Act through June 30, 1955.

Ohio became eligible for participation in the program as of the fiscal year 1948, which ran from July 1, 1947, through June 30, 1948. In that year, Ohio received Federal grants-in-aid amounting to $2,690,189. The following year, July, 1948-June, 1949, the allotment was $2,715,846.

Under the new appropriation, the amount allotted for the year July, 1949-June, 1950, is $5,979,473. Approximately the same amount will be available each year through June of 1955.

The original Act appropriated $75,000,000 of Federal Funds to be shared among the states which qualified to participate in the program. Amendments to the Act by the 80th Congress increased the over-all amount to $150,000,000. Appropriations are made to the states according to population.

Liberalized terms of the amendments make more flexible the percentage of Federal Participation. Under the original Act the Federal government would appropriate one-third of construction costs. If a state continues to operate with the former percentage ratio, it may approximately double the volume of construction approved under the plan. The Ohio Hospital Advisory Council is recommending to the Surgeon General that the ratio of 33-1/3 per cent be maintained as the Federal contribution on all general hospital projects in Ohio. It is further recommending that the Federal proportion be increased in projects involving the special facilities, such as chronic disease, mental, tuberculosis and health centers.

PROGRESS REPORT

A progress report issued by Anthony J. Borowski, Dr. P. H., head of the Ohio Hospital Facilities Office, showed that as of November 1, 29 hospital projects had been initially approved by the Surgeon General of the U. S. Public Health Service. Of these 29 projects, 16 are fully approved and under construction.

The entire building program, up to the time additional grant-in-aid funds were approved, provided for 2,464 additional beds in Ohio, distributed as follows: General, 1,415; chronic, 854; tuberculosis, 195.

The total estimated cost of these beds is $31,503,265.72, with $8,498,864.98 as the Federal grant-in-aid share. Ohio, which ranks fourth among the states in the amount of funds received, is third in the total number of new beds provided, Dr. Borowski announced. He added that Ohio has provided more chronic disease beds under this program than the other 47 states and four territories combined.

MORE HEALTH CENTERS URGED

Building of health centers in conjunction with hospitals is strongly urged in the Ohio program; the administrator continued. Such an arrangement provides adequate facilities for operation of a good public health program. A health center in this connection in general means housing for the local health department with certain diagnostic and laboratory facilities available for public health work.

The following 13 communities will have hospitals with health centers: Washington Court House, Xenia, Chillicothe, West Union, Nelsonville, Marysville, Ironton, Defiance, Cambridge, Wooster, Dover-New Philadelphia, Alliance and Montpelier.

In addition to providing fiscal aid for construction of hospitals, the services of the Hospital Facilities Office of the Ohio Department of Health are available to any community or hospital for site selection, review of architectual plans, equipment, nursing and dietary consultation and other related activities regardless of whether financial assistance is solicited or given for hospital construction.

Ohioans Participate in Annual Southern Medical Meet

Many Ohio physicians took part in the program of the Southern Medical Association for its 43rd annual meeting in Cincinnati, November 14-17. Among those who participated were the following, of Cincinnati: Drs. Carl W. Kumpe, Harold Kotte, William A. Altemeier, Louis A. Lourie, Edgar S. Lotspeich, Jr., Robert A. Lynn, Katherine Dodd, Frederic N. Silverman, Ashton L. Welch, Leon Goldman, Charles E. Howard, Stewart R. Jones, Henry M. Goodyear, Clarence Mills, Donald J. Lyle, Richard A. Hoffman, and Stanley A. Dorst. Among Ohio participants from other parts of the State were the following: Drs. Lester W. Sontag, Yellow Springs; Robert J. Murphy, Columbus; Walter A. Hoyt, Akron; and Joseph Charles Placak, Cleveland.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SPUNK SHOWN BY HEALTH OFFICERS

At the recent conference of State and Territorial Health Officers in Washington, D. C., the conference adopted a resolution expressing "disapproval of the proposed compulsory health insurance legislation now being considered."

The resolution pointed out that the people of this country now enjoy the highest standards of health of any country; that the progress in preventive medicine, environmental sanitation, health education and organized public health service has been a big factor in the evolution of our high health standards; and that the pending legislation does not include adequate provisions for preventive medicine and modern public health services.

In our opinion, the health officers deserve a bouquet for their courage. It took courage to take this action in view of the fact that they were at Washington as guests of the big boss, Social Security Administrator Oscar Ewing, whose views in favor of compulsory health insurance are well known.

Some may say that the public health officers' action was too mild. That's not a good point. The big point is that action opposing the pending legislation was taken and was taken by a group of officials who stand to gain in bureaucratic power if compulsory health insurance becomes a reality. Chalk up another victory for sincerity over expediency!

MEDICAL SOCIETY PROBES BECOME BOOMERANGS

Recent inspection of the files of the Columbus Academy of Medicine, the Cleveland Academy of Medicine, and the Summit County Medical Society by agents of the Department of Justice and on the demand of that agency, has created quite a furore on the editorial pages of many Ohio newspapers.

Taking their pens in hand, the editorial writers really teed off on the Department of Justice, the Truman Administration, and even the F. B. I. which they pointed out always had held the respect of the public but which had been forced into "this shabby job" and "fishing expedition" because it had been ordered to do so from the throne room.

Officials of the three Ohio societies "investigated" (before any charges had been preferred and without any idea of what the probers were looking for) are of the opinion that their records are clean and that the agents found no evidence of violations of the anti-trust laws, or whatever the investigators were looking for. Obviously, the Department of Justice has issued no statement on these cases—probably won't unless they found some dirt, which is unlikely.

The officials of the three societies issued strong, well-prepared statements to the press on what they considered a "smear the doctors" project. These received wide publicity. The public's reaction appeared to be on the side of the medical profession for having been forced to submit to Gestapo tactics, which were a "violation of basic rights." As the *Columbus Academy of Medicine Bulletin* said on the incident:

"Based on widespread comment of patients in many doctors' offices and other reports coming to the Executive Office of the Academy, the prompt and forceful action of Council has turned an ignominious, partisan attack upon the medical profession into a distinct asset in creating good will with the public in the doctors' fight to forestall the enactment of compulsory health insurance—the entering wedge for complete socialized medicine."

BEFORE YOU BUY HEALTH AND ACCIDENT INSURANCE—

In our opinion, C.P.P. editorializing in the November issue of the *Columbus Academy of Medicine Bulletin* hands out some good advice on the matter of what to buy and not to buy in the way of health and accident insurance. It follows the theme of before you invest, investigate. Read what he has to say and weep—or pat yourself on the back for having made a good purchase:

"Periodically I feel the urge to give some advice concerning the purchase of health and accident insurance. I encounter so many patients who have bought a pig in a poke, that I wonder if anyone ever reads the insurance policy he buys. When I think about it, I realize that we don't see the policy, usually, until we have paid for it.

"A good way to judge the kind of insurance you are buying is to look over the blank you must fill in and the blank your attending physician must fill in, at the time of illness, before you purchase the insurance.

"If the blank is short and to the point, contains simple questions and few of them, then it is likely that the insurance is good.

"But if there are thirty questions, more or less, for you to answer and an equal number for your doctor, and there is a lot of the 'confined to bed, able to go out of doors, able to do any kind of work, how many visits to the home, what was the treatment, is it chronic, is there any

contributing constitutional factor,' type of question, Brother, you better look elsewhere, because you probably ain't gonna git your money when you think you are!"

HERE'S A CHANCE TO GET INTO ACTION

We see by the 'papers that the Ohio Junior Chamber of Commerce is planning a state-wide "get out the vote" project and is going to encourage young men to enter political life. More power to 'em!

Each County Medical Society should have a similar project—for doctors and members of their families.

Incidentally, most Junior Chambers of Commerce are live-wire groups. If younger physicians are not members, and are eligible for membership, they should join. No, the Junior Chamber of Commerce has not requested this plug. It just is good common sense, in our opinion, for physicians to get into worth-while organizations in their community.

THERE ARE TOO MANY OF THIS KIND IN OFFICE, OBVIOUSLY

If you have not done so, read the article, "What Will Congress Do In 1950?," published elsewhere in this issue. It will stimulate your thinking—should stimulate you into action now —and in 1950.

The article quotes statements made by Congressman Crosser, Cleveland, Ohio, solon, as advocating some kind of national health program.

Commenting on Mr. Crosser's opinion, one Washington commentator made the following pertinent observation: "Mr. Crosser is not among those who worry about whether the government is going to keep running into the red, obviously. Even the United States plan would cost a considerable amount of money, during its first years at least, and a British-type plan would run into astronomical figures."

Unfortunately there appear to be too many members of Congress who don't worry about "whether the government is going to keep running into the red, obviously." The voters will have a chance to correct that situation in November, 1950.

HOW NOT TO WIN CONVERTS FOR U. S. MEDICAL PLAN

The Scripps-Howard chain of newspapers has been conducting a survey in many cities throughout the country on medical and hospital costs, supply of physicians, medical school enrollments, etc. A series of articles on the findings has been appearing in the S-H papers.

One of these articles charges that in some cities certain hospitals are requiring patients to pay prices for drugs which are considerably more than the amount charged the hospital by the wholesale drug firm.

It would be well for the management of hospitals where this practice is followed to give the matter serious consideration. It might be considered fair for the hospital to tack onto the costs of drugs a reasonable amount for handling charges but the amount should be nominal.

Excessive charges of this kind are responsible in part for the high bills issued by some hospitals. The high costs of hospitalization are the cause of a great deal of discontent among patients, converting some of them to the belief that a governmental plan is the only solution.

Along this same line is the warning found in figures issued by the Blue Cross hospitalization plans. Five years ago 100 out of every 1,000 Blue Cross members were admitted to hospitals annually. By 1948, the rate had increased to 125 out of every 1,000 members. Now the figure stands at 154 per 1,000 members. This has required an increase in the subscription rates in many areas. The risk of losing members is great when subscription fees are increased. Unless the trend is controlled, the loss in Blue Cross members could become critical. The only alternative for those who could not pay the higher fees would be a government plan.

Physicians who are on the admitting end of the hospitalization of Blue Cross members can play a vital part in helping to control this situation. Only patients who need hospital care should be certified. Patients should not be certified to the hospital solely for their own convenience or the convenience of the attending physician.

"WHO GETS THE WELFARE IN THE WELFARE STATE?"

"Who gets the welfare in the 'welfare state'?"

That was the heading on an advertisement of a large industrial concern, published in recent issue of several magazines.

Here's the rest of the ad—the answer to the question—which should make any thinking person sit up and take notice:

"That's easy: the state. Which is to say, the bureaucrats.

"There's a formula. You've seen it. Be sure you recognize it next time. Here's how it goes:

"Somebody promises to give you something (a subsidy or a wage increase without a production increase), if you'll give him a little something in return—just a little something—a vote, perhaps.

"So, you give and you get. Or you think you do. Maybe what you get increases the national debt or decreases corporation profits. What do you care? Let's see:

"National debt? That's mortgaging your

child's future. Let the rich pay it? That's silly. Take every penny every one of them has, and you wouldn't make more than a dent in the national debt. Every dollar added to it by the give-away bureaucrats has to be paid back by you and your children and your grandchildren.

"Take it out of corporation profits? If all the profits of all the corporations were taken, you would pay only a tiny fraction of the national debt.

"The plain truth is that no one can give you anything. Last year the Federal government said it 'gave' to the states five and a half billion dollars. That money, of course, first came from the states. But $625,000,000 of it never got back to the states—that was the cost of taking it away from you, and giving part of it back.

"When anyone promises you something for nothing, you can be sure he gets a lot of the something, and you get a lot of the nothing."

POST MORTEM ON RECENT ELECTIONS

Few physicians acquainted with current trends will doubt that it is necessary for the medical profession to take an active, direct interest in political activities—like it or not.

For this reason, and because the Ohio Congressional elections in 1950 will be of vital importance not only to Ohio but to the entire country, a brief post mortem on the recent senatorial election in New York State and elections in other states would appear to be in order. Ohioans may be able to learn a few lessons from the results.

Proponents of the "welfare state" have hailed the victory of Herbert Lehman over John Foster Dulles as an indication of a national trend. Let's look at that for a moment.

True, Lehman did endorse the Truman welfare program (he did state, however, he was opposed to "socialized medicine" but didn't define the term). But, there were many other factors involved, each of which had a bearing on the final outcome.

Lehman, a former governor and lieutenant governor of the state, as well as an ex-representative of the country on certain foreign assignments, was known in all parts of the state. Dulles, in comparison, was a newcomer in politics.

The victory of O'Dwyer as mayor of New York City helped Lehman in that area. The fact that Upstate New York, which is normally Republican, did not turn out in the number expected, hurt Dulles. The racial and religious issues which were thrown into the campaign undoubtedly clouded the real issue and produced votes for the former New York governor.

Looking elsewhere for trends, we find that the voters in California adopted a new constitutional amendment, nullifying some of the drastic provisions of the old age pension amendment adopted in 1948 which saddled a gigantic pension program onto the state and was really the "welfare state" to the Nth degree. Ohio voters adopted a constitutional amendment ending straight-ticket voting—a move which will aid Senator Taft's chances next year, it is believed. Governor Driscoll was re-elected governor of New Jersey on a liberal platform but one which was far short of the extremes of the Truman program. These results indicate that not all the voters have veered to the left.

There may be other trends but these are enough to show some of the cross-currents which may appear during the 1950 campaigns and elections. A few things are fairly obvious and must be kept in mind by those in Ohio who want to see a strong Ohio delegation in the 82nd Congress.

Every possible effort will have to be made to arouse the interest of business and professional people in the 1950 campaigns and candidates; to get them qualified to vote; to get them to the polls on election day. If large numbers of voters stay away from the polls, candidates supported by radical groups will win.

The people will have to be fully informed on the main issues—not allowed to base their decisions on the sideshows and on ideological hokum.

Candidates who expect to win will have to be affirmative, rather than negative. They will have to understand that you can't lick something with nothing.

When the battle in Ohio starts after the first of the year, there can be no muffing the ball. Conservative Ohio voters and candidates should profit from what transpired in some of the other states.

BOUQUET FOR DOCTORS OF FRANKLIN COUNTY

Our hat comes off this month to the physicians of Franklin County for the splendid cooperation they gave to the recent Community Chest campaign in that county. The medical profession of Franklin County not only subscribed its quota and a bit more, being one of the few divisions to do so, but it also did the job with a vim and vigor which made everybody sit up and take notice.

This, in our opinion, is good public relations —the kind which pays real dividends. The day is past when the medical profession can sit back and let others carry the ball on civic and community activities. Doctors want—need—the cooperation of the public, especially these days. That being the case, they must realize that cooperation is a two-way street. The physicians of Franklin County—at least most of them—have indicated that they have learned that lesson. Here's hoping physicians all over Ohio will follow suit.

State Welfare Building Program . . .

Legislative Appropriation Makes Possible Construction of Numerous Additions at Institutions; Progress Report on Other Projects Given

THE State Board of Control has authorized the Ohio Department of Public Welfare to proceed with a new building program under appropriations recently made by the Ohio General Assembly amounting to $10,176,000. Judge John H. Lamneck, director of public welfare, has announced.

The construction authorized includes the following:

Athens State Hospital—One physician's residence, $18,000.

Cleveland State Hospital—One physician's residence, $25,000; one 150-bed dormitory, $165,000.

Dayton State Hospital—One single and one double physician's residence, $50,000; one 150-bed dormitory, $150,000.

Hawthornden State Hospital—Two 150-bed dormitories, $270,000.

Lima State Hospital—One double physician's residence, $30,000; addition to administration building, $90,000; psychopathic building, 300 beds, $1,450,000.

Longview State Hospital—One 150-bed dormitory, $150,000.

Massillon State Hospital—One double physician's residence, $30,000.

Mt. Vernon State Hospital—One double physician's residence, $30,000.

Tiffin State Hospital—Three 150-bed dormitories, $450,000; addition to Hospital building, $150,000.

Toledo State Hospital—Addition to Medical building, $135,000; one 15-bed dormitory, $150,000; one double physician's residence, $30,000.

Youngstown Receiving Hospital—Addition, $800,000.

New Receiving Hospital, Portsmouth, $900,000.

Apple Creek State School—Employees' building, $450,000; two 150-bed dormitories, $275,000; one single physician's residence, $18,000; one double physician's residence, $30,000.

Orient State School—One 150-bed dormitory, $150,000.

New Reformatory—$3,250,000.

Ohio Reformatory for Women—One new cottage, $180,000; laundry building, $150,000.

Marion Training School—Receiving building, $200,000.

Bureau of Juvenile Research—Receiving and hospital building, $400,000.

The foregoing appropriations do not include the new receiving hospital to be constructed at Cincinnati, at an estimated cost of $900,000, nor the new employees' building at Mt. Vernon State Hospital, estimated at $270,000. An addition to the Cleveland Receiving Hospital at an estimated cost of $600,000 also is being planned.

New units for the Department of Public Welfare which have been completed recently include:

New Receiving Hospital at Athens—$600,000.

New Hospital at Apple Creek State School—$3,500,000.

Veterans' Building at Longview State Hospital—$300,000.

Refractory Ward at Longview State Hospital—$300,000.

Hospital Building at Marysville Reformatory—$750,000.

Other projects now under construction include:

The Receiving Hospital at Ohio State University—$2,000,000.

Six buildings at Hawthornden State Hospital, aggregating $3,000,000.

Employees' Building at Cleveland—$350,000.

New dormitory and addition to power plant at Apple Creek State School—$1,500,000.

Many Ohioans Take Part in American Public Health Assn. Meet

Dr. John D. Porterfield, director of the Ohio Department of Health, was elected secretary of the Health Officers' Section of the American Public Health Association at the annual meeting of that organization October 24-28 in New York City.

Among those who presented papers at the session were the following from Ohio: Dr. George F. Badger, Western Reserve University, Cleveland; Dr. A. O. DeWeese, director of health, Kent State University; Dr. John H. Dingle, Western Reserve University, Cleveland; Dr. A. E. Feller, W. R. U.; Dr. Bruno Gebhard, director of the Cleveland Health Museum; Miss Reba F. Harris, Ohio Department of Health, Columbus; Dr. Richard G. Hodges, W. R. U.; Dr. William S. Jordan, Jr., W. R. U.; Thomas Knowles, General Electric Co., Cleveland; Beatrice D. Larner, D. Sc., U. S. Marine Hospital, Cleveland; E. T. Leppelmeier, G. E. Co., Cleveland; Matthew Luckiesh, D. Sc., G. E. Co.; Dr. Thomas F. Mancuso, chief, Industrial Hygiene Division, Ohio Department of Health, Columbus; Dr. John J. Phair, University of Cincinnati; Dr. John D. Porterfield; Dr. Charles H. Rammelkamp, Jr., W. R. U.; Dr. Thomas E. Shaffer, Ohio State University, Columbus; Albert H. Stevenson, senior sanitary engineer, Environmental Health Center, Cincinnati.

Do You Know? . . .

Dr. Milton M. Parker, assistant professor of neurology and psychiatry, Ohio State University College of Medicine, has been named medical consultant on epilepsy to the Ohio Society for Crippled Children. He succeeds Dr. Jerry C. Price, formerly of New York and now engaged in epilepsy research in Los Angeles.

* * *

A charter member and secretary-treasurer of the American Student Health Association, Dr. A. O. DeWeese, Kent State University director of student health, was honored with the William A. Howe award for leadership in health education at the Association's recent meeting in New York City.

* * *

Charles S. Nelson, Executive Secretary, Ohio State Medical Association, was one of the speakers at the annual A. M. A. Conference of State Medical Association Secretaries and Editors held in Chicago, Nov. 3-4. He discussed: "Office and Personnel Management in the Expanding Headquarters of State Medical Associations." Also attending the meeting and the two-day Public Relations Conference which followed were: George H. Saville, Hart F. Page and R. Gordon Moore of the O. S. M. A. Staff.

* * *

Dr. Harve M. Clodfelter, Councilor for the 10th District of the Ohio State Medical Association, was interviewed on "Socialized Medicine," Monday evening, November 14, on the program entitled "Headlines" sponsored weekly by the Columbus Real Estate Board over Radio Station WCOL, Columbus.

* * *

Dr. Clarence O. Sappington, editor of *Industrial Medicine and Surgery*, and national authority in his field, died in Chicago November 7, aged 61.

* * *

A total of $161,572,811 was paid to hospitals by 90 Blue Cross plans for care of Blue Cross members during the first six months of 1949. This amount represents 87.64 per cent of the income of the plans. Operating expenses took only 9.11 per cent of the income—an all-time record for low-cost administration.

* * *

Brig. Gen. Richard L. Meiling, U. S. A. F. Reserve, Director of Medical Services, Office of the Secretary of Defense, was one of the speakers on a symposium on the Problems of the Reserve Officers of the Armed Forces during the annual meeting of The Association of Military Surgeons of the United States, held in Washington, D. C., Nov. 10-12.

Damage suits totaling $225,000 have been filed against the Lake Wales, Florida, Hospital, following the deaths of four infants attributed to the absorption of aniline dye on hospital diapers. The commercial laundry serving the hospital also was named in the damage suits.

* * *

It has been estimated by the Research Council on Problems of Alcohol that 50,000,000 persons in the United States use alcoholic beverages; that of this number, 6 per cent, or 3,000,000 become excessive drinkers, and in the latter group, that nearly one-fourth, or 750,000, are said to be chronically alcoholic.

* * *

The new President of Northwestern University is Dr. J. Roscoe Miller, Dean of the Northwestern Medical School since 1941. Dr. Miller was President of the Chicago Medical Society last year.

* * *

Dr. John A. Toomey, Cleveland, spoke on the subject: "Is Week's Virus Due to Poliomyelitis?" at the 18th annual meeting of the American Academy of Pediatrics held at San Francisco, November 14-17.

* * *

"What in 1950?" was the topic discussed by Charles S. Nelson, Executive Secretary, Ohio State Medical Association, at a meeting of the Woman's Auxiliaries of the Second Councilor District, Wednesday noon, November 2, at the Miami Hotel, Dayton. Mrs. Robert A. Taft was a guest at the luncheon.

* * *

There were 145,036 members of the American Medical Association on September 1, 1949, an increase of nearly 10,000 in two years.

* * *

George H. Saville, Director of Public Relations, Ohio State Medical Association, spoke on "Uncle Sam, M. D.?" at a meeting of over 100 community leaders of Huron County, November 11, at Norwalk. The meeting was arranged by the recently organized Woman's Auxiliary to the Huron County Medical Society, of which Mrs. A. H. Kimmel is president.

* * *

Of nearly $7,000,000 spent for tuberculosis research in the United States in a twelve months' period during 1947-1948, about two-thirds was spent for the study of drugs in tuberculosis treatment, according to *Ohio Public Health*. This amount included $1,767,000 spent by the Veterans Administration for its studies on the effect of streptomycin in tuberculosis.

On the Firing Line . . .

Shots at Truman-Ewing Compulsory Sickness Insurance Scheme; Ammunition For Doctors in Speeches Against Federalized Medicine

"America is on the march to socialism . . . The deficit financing of Federal programs in time of peace is piling up a Federal debt to proportions in which the liberties of free enterprise cannot survive." — *Senator Harry F. Byrd (D), Virginia, October 12, 1949.*

* * *

"Over-spending, over-taxing, and over-dependence on the state—these are the great democratic weaknesses. They can do a lot more to pave the way for a Communist triumph than all the Red conspirators can do to us. And the tragedy is that we do these things to ourselves."—*E. T. Leech, editor, The Pittsburg Press.*

* * *

"Whether these newest eras are right or wrong, 'security' which eliminates the risks in life, also kills the joy that lies in competition, in individual adventure, new undertakings, and new achievements. These contain moral and intellectual impulses more vital than even profits. For from them alone comes national progress. At all times in history there have been many who sought to escape in 'security' from self-reliance." —*Herbert Hoover, at Ohio Wesleyan University, June 11, 1949.*

* * *

"The American people are being bled white and into complete regimentation through taxation alone."—*Rep. Clarence Brown (R), Ohio, September 27, 1949.*

* * *

"The London Economist coins a word, 'benefititis,' to describe the practice of getting benefits without real need. It also brings to our attention a British word which is not well known to us, 'scrinshanking.' This word means the deliberate exaggeration of a symptom which marks an illness that enables a person to take time off, with benefits."—*Raymond Moley in the Columbus Dispatch.*

* * *

"We must see this English experiment clearly because the plan by which England was sneaked into socialism is now being promoted in this country by a coalition of politicians and revolutionary crusaders who are the counterpart of the British Fabian Socialists. . . . And it is a grave question whether or not the program has been already so far advanced that reversal may be impossible. But this much is certain—it must be reversed and that at once or we will find ourselves trapped in a Socialist system in far shorter time than was required to conquer England."—*John T. Flynn, The Road Ahead.*

* * *

"Oscar Ewing, who is most responsible for the war on doctors, is a lawyer and does not advocate the socialization of lawyers. He knows that most members of Congress are lawyers and they would fall upon him like a herd of elephants on the rampage."—*George E. Sokolsky in the Columbus Dispatch.*

* * *

"I haven't been to the doctor since the new scheme was brought in. I hope soon to have an overhaul, and for that I intend to go privately to another doctor, as I do not feel that I would be happy in getting free service for a non-essential thing like that, apart from feeling that it would be superficial."—*Bank Official, Aged 40, quoted in British National News Letter, Mass Observation Report.*

* * *

"To operate a government health scheme requires complete government control or it won't work."— *British Minister of Health Bevan in interview with John McPherrin, editor, The American Druggist.*

* * *

". . . Forty per cent of the entire British income goes to taxes. It is a burden so vast that it discourages work, stifles enterprise and destroys hope. Britain has passed the much-discussed point of diminishing returns. In America we are approaching the point where all taxes take 30 per cent of income. And if we keep taking on new obligations and launching into new spending projects, we, too, will reach the 40 per cent stage."—*E. T. Leech, editor, The Pittsburgh Press.*

* * *

". . . The degradation of the G. P. (in England) is no remote danger. It is in progress. A recent poll of second-year students at Guy's Hospital, one of London's greatest 'teaching hospitals,' showed only four out of 68 who planned to enter general practice."—*Morley Cassidy, in The Canton Repository.*

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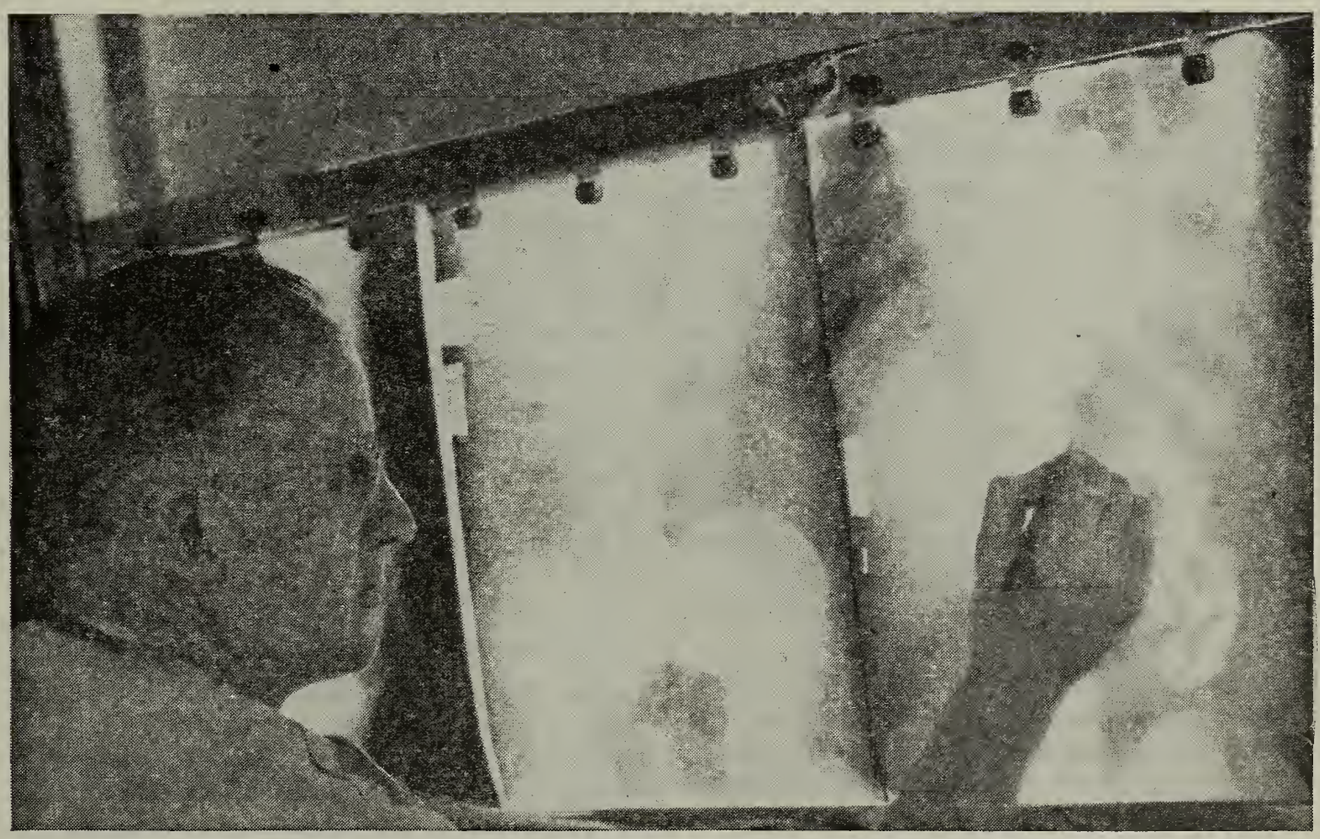
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RESEARCH IN THE SERVICE OF MEDICINE

Water Analysis Offered in Blue Baby Cases by Health Department

In order that the contents of local water supplies may be studied as potential contributing causes of methemoglobinemia in infants ("blue baby" illness), Dr. John D. Porterfield, director of the Ohio Department of Health, is requesting physicians throughout the State to inform the Department of each "blue baby" case.

When a case is reported to the Columbus office of the Department of Health, Dr. Porterfield assured, the Department will make an analysis of the local water supply to determine whether it contains nitrates in sufficient quantity to be considered a contributing cause of the condition.

The Engineering Division of the Department of Health has carried on extensive research upon the subject of nitrate nitrogen content of water supplies in Ohio for the past year and a half, during which time more than 25,000 water samples were analyzed, Dr. Porterfield revealed. As a result of these analyses a number of pertinent observations have been made.

Municipal water supplies are free from amounts large enough to cause concern in the incidence of methemoglobinemia in infants.

Rural water supplies, on the other hand, in many instances showed significant amounts of nitrate nitrogen. About three per cent of the total wells tested showed nitrate nitrogen content of more than 10 parts per million.

The vast majority of the high nitrate waters—those testing more than 20 parts per million—were from shallow dug or driven wells. These wells were for the most part susceptible to surface influences, as revealed by both bacterial analyses and sanitary inspections.

Preliminary studies of these high nitrate-bearing wells indicate the probability of the nitrogen source being from nitrate-producing plants growing in the immediate vicinity of the wells. This observation is strengthened by the seasonal variation between the months of highest and lowest nitrogen content of the well waters —June was uniformly the highest; December the lowest.

The remedy for the condition, Dr. Porterfield said, is for the family to abandon the shallow well for a deep drilled well properly located and protected.

Reports on the relationship between methemoglobinemia in infants and the nitrate content of water have appeared in medical literature for several years, Dr. Porterfield reported, but only recently has the full significance of this relationship been recognized. In general, a nitrate content of 10 parts per million is the maximum that can be tolerated by infants without potential ill effects, the health director said.

Buckeye News Notes . . .

Alliance—The 50-Year Pin and Certificate of the Ohio State Medical Association was presented to Dr. H. C. Temple at a meeting of the staff of City Hospital. The presentation was made through the Stark County Medical Society by Dr. George M. Wilcoxon.

Cincinnati—Dr. H. H. Wiggers, at the age of 80, was distinguished as the sole survivor of the original medical staff of the Bethesda Hospital at the 53rd annual Fellowship Day celebration.

Cincinnati—Dr. Robert Perlman, University of Cincinnati College of Medicine, was one of three civilian physicians who made a trip to Japan as medical consultants to the Army medical corps. Others were Dr. H. F. Klinefelter, Jr., Johns Hopkins University, and Dr. Luman E. Daniels, University of Colorado.

Columbus—Dr. Thomas E. Rardin, president of the Metropolitan Health Council, spoke on "Mental Health Within the Family," at a meeting of the Bide-A-Wee Child Conservation League and the Bexley C. C. L.

Madison—Dr. Walter C. Corey has resigned as Geauga County health commissioner after serving for 25 years in that capacity.

Mansfield—Dr. W. E. Wygant addressed the Exchange Club on the subject of socialized medicine.

Nelsonville—Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, spoke at the 90th anniversary homecoming of the local Christian Church. He is a native of Nelsonville.

New Lexington—Dr. Alton J. Ball is chairman of the 1949 Christmas Seal Sale in Perry County.

New Philadelphia—Dr. Burrell Russell took part in a discussion on socialized medicine at a meeting of the Home and School Association of Stone Creek-Jefferson School District.

Toledo—A news photograph in the *Toledo Blade* pictured Dr. Foster Myers, president of the Academy of Medicine of Toledo, and Dr. Warren A. Baird with Gilbert H. Siegel, president of the Lucas County Pharmaceutical Association. The occasion was the annual Physicians' and Pharmacists' Dinner sponsored by the Pharmaceutical Association.

Willard—Dr. H. K. Shumaker of Bellevue discussed the subject, "Your Heart," at a meeting of the Rotary Club.

Yellow Springs—Dr. L. L. Taylor was honored with a family reunion on the occasion of his 86th birthday.

Zanesville—Dr. Beatrice T. Hagen has announced her resignation as Muskingum County health commissioner effective January 1. She has served 20 years in that capacity.

In Memoriam . . .

Carl Clinton Borden, M. D., Miamisburg; Ohio State University College of Medicine, 1915; aged 56; died October 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association; first vice-president of the Montgomery County Medical Society in 1932.

Charles Clarence Campbell, M. D., Ashtabula; Starling Medical College, Columbus, 1906; aged 69; died October 1; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Ashtabula County Medical Society in 1941. Dr. Campbell had practiced his profession in Ashtabula and vicinity for 43 years. He was a member of the Elks Lodge and several Masonic orders. Surviving are his widow, two brothers and two sisters.

Dudley V. Courtright, M. D., Circleville; Starling Medical College, Columbus, 1897; aged 74; died November 2 in Paris, Ky., from injuries received in an automobile accident; member of the Ohio State Medical Association and a Fellow of the American Medical Association; treasurer of the Pickaway County Medical Society, 1918; its secretary, 1919-22; chairman of the legislative committee, 1926; delegate to the Ohio State Medical Association, 1930-31 and 1935; vice-president in 1933, and president in 1934 and from 1939 until time of death. Dr. Courtright began his practice in Circleville in 1900. He was active in the work of the Elks and the Masonic lodges. Surviving are four sons and a daughter.

Roy Hamilton Davis, M. D., Monson, Mass., University of Cincinnati College of Medicine, 1912; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American Urological Association. Dr. Davis had practiced medicine in Dayton for approximately 34 years before moving to Massachusetts after retiring about a year ago. In addition to his private practice, he was associated with the Public Health Clinic in Dayton. Surviving are his widow, two daughters, a brother and two sisters.

Charles Cyrus Hatfield, M. D., Kingston; Starling Medical College, Columbus, 1894; aged 82; died October 30; former member of the Ohio State Medical Association and the American Medical Association through 1932. Dr. Hatfield had practiced his profession in Kingston for approximately 53 years and retired only a few years ago. He was a veteran of World War I.

Emil J. Heinig, M. D., Vermilion; Western Reserve University School of Medicine, 1898; aged 73; died October 29; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Lorain County Medical Society in 1929. Dr. Heinig had practiced medicine in Vermilion and vicinity for approximately 39 years. In addition to his professional work he was active in community affairs. He was a charter member and past-president of the local Rotary Club, and held memberships in the Masonic Lodge and the Evangelical Reformed Church. Surviving are his widow, a daughter, his mother, a sister and a brother.

Thomas Herbert Infield, M. D., Zanesville; Baltimore Medical College, 1897; aged 79; died November 4; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1945. Dr. Infield had practiced in Zanesville for 40 years. At one time he was engaged in public health as city milk examiner. He was a member of the Masonic Lodge and the Presbyterian Church. Surviving are his widow, a son, two daughters, a sister and three brothers.

Edgar Horace Knowlton, M. D., Mantua; University of Wooster Medical Department, 1902; aged 75; died October 7 in a traffic accident; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary of the Portage County Medical Society in 1921; its president in 1934, and chairman of the legislative committee in 1945. Dr. Knowlton had practiced medicine in Portage County for 48 years and in addition to his professional work was active in many phases of community life. He served as village mayor and councilman and was president of the school board. He was active in the work of the Portage County Health Department which he helped organize. He had served continuously as president of the County Board since its inception. He was active in several Masonic orders and was a member of the Elks Lodge and the Methodist Church. As a veteran of World War I, he was a member of the American Legion. Surviving are his widow who was injured in the same accident; two sons, Dr. Richard S. Knowlton of Cleveland and Dr. Edgar A. Knowlton of Mantua, and a brother.

Roscoe Genung Leland, M. D., Chicago; University of Michigan Department of Medicine and Surgery, 1909; aged 64; died October 17; member of the Ohio State Medical Association and the American Medical Association. Shortly after returning from service after World War I, Dr. Leland became associated with the Ohio Department of Health where he served as chief of the Division of Hygiene and later became executive secretary of the Toledo Public Health

Association. He then went to Chicago where he was assistant director of the A. M. A. Bureau of Health and Public Instruction and in 1931 became director of the newly formed Bureau of Medical Economics. During World War II, he was appointed supervisor of the consultant office in the headquarters of the A. M. A. for Procurement and Assignment Service for Physicians, Dentists and Veterinarians, and also was appointed a member of the Health and Medical Committee of the Selective Service System. He was a fellow of the American Public Health Association, a member of the Royal Economic Society of England, the American Economic, American Statistical and National Education Associations. His widow survives.

Ben S. Leonard, M. D., West Liberty; Medical College of Cincinnati, 1880; aged 93; died November 4; former member of the Ohio State Medical Association and the American Medical Association through 1931; president of the Logan County Medical Society in 1931. Dr. Leonard was a life resident of Logan County and practiced in West Liberty until his retirement in 1932. He was a former postmaster of West Liberty and was a director of the Ohio National Life Insurance Co. of Cincinnati. Surviving are a daughter and a sister.

Robert Jones McGuinness, M. D., Belvedere, Calif.; Jefferson Medical College of Philadelphia, 1920; aged 55; died November 3; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. McGuinness had practiced medicine for 23 years in Columbus before leaving for California last April. He was a member of the Catholic Church. Surviving are his widow, three daughters, four sons and a brother, Dr. George McGuinness of Chicago.

Ralph Frederic Reno, M. D., Cincinnati; Cincinnati College of Medicine and Surgery, 1897; aged 76; died October 12; former member of the Ohio State Medical Association and the American Medical Association in 1944. Dr. Reno's entire professional career was spent in Cincinnati. He retired several years ago. Surviving are his widow and two daughters.

Louis Elmer Siegelstein, M. D., Cleveland; New York University Medical College, 1894; aged 76; died October 8. Dr. Siegelstein had practiced in Cleveland since 1898 and at one time served as Cuyahoga County Coroner. He was a charter member of the City Club, held memberships in several Masonic orders, the Chamber of Commerce and other civic organizations. Surviving are his widow and three children.

Stephen Ulysses Sivon, M. D., Ravenna; University of Wooster Medical Department, Cleveland, 1912; aged 63; died October 16; member of the Ohio State Medical Association and a Fellow of the American Medical Association; secretary of the Portage County Medical Society, 1924; delegate to the O. S. M. A., 1926 and 1934; vice-president, 1928 and 1930, president in 1933, and chairman of the legislative committee, 1939-43. Dr. Sivon had practiced his profession in Ravenna for 31 years. For 25 years he was surgeon for the Erie Railroad. He was active in promoting local school athletics, and held memberships in the Kiwanis Club, the Elks Lodge and the Christian Church. Surviving are his widow, two daughters, one of whom is Dr. Iola A. Sivon of Columbus, two sons, two brothers and two sisters.

John Reis Stark, M. D., Cincinnati; University of Cincinnati College of Medicine, 1916; aged 56; died October 16; former member of the Ohio State Medical Association and Fellow of the American Medical Association through 1946. Dr. Stark retired from private practice in 1946 and devoted his time to research at General Hospital. He also was active on the staff of Jewish Hospital. He was a past-president of the Sharonville Kiwanis Club. Surviving are his widow, a daughter and a son.

Willis Arthur Whitman, M. D., Middletown; Ohio State University College of Medicine, 1921; aged 63; died November 2; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Whitman began practice in Middletown in 1924 and in addition to his professional work was active in community affairs, among which was his promotion of the Boy Scouts. Surviving are his widow, a son, a daughter and a brother.

The Trudeau School of Tuberculosis will present its 1950 four weeks' course in Saranac Lake, N. Y., beginning May 1. Information may be obtained by writing: The Secretary, Trudeau School, Saranac Lake, N. Y.

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Activities of County Societies . . .

First District

(COUNCILOR: D. W. HEUSINKVELD, M. D., CINCINNATI)

ADAMS

Talks illustrated by charts and movies were given by Miss Lillian Derflager and Miss Flora Williams of the Ohio Department of Health, Columbus, at the Oct. 13 meeting of the Adams County Medical Society in Seaman. Dr. R. L. Lawwill and members of the local health department staff were hosts. Dinner was served by a class of the Seaman Methodist Church.

BUTLER

Three doctors were presented 50-Year Pins and Certificates at the Oct. 26 meeting of the Butler County Medical Society in Hamilton. They are: Dr. William H. Henry, Middletown; Dr. R. H. Cook of Oxford, and Dr. O. J. Smith of Venice. Dr. E. O. Swartz, Cincinnati, President-Elect of the Ohio State Medical Association, presented the awards in behalf of the Association.

HAMILTON

The Academy of Medicine of Cincinnati had as guest speaker on Nov. 8, Dr. Raymond N. Bieter, University of Minnesota Medical School, who spoke on "Drugs Used for the Control of Pain."

At the Nov. 22 meeting, Dr. Thomas Francis, Jr., University of Michigan, Ann Arbor, spoke on the subject, "Influenza—The Clinical Epidemiological and Public Health Significance of Multiple Immunological Types of Virus."

Second District

(COUNCILOR: M. D. PRUGH, M. D., DAYTON)

CLARK

The November business meeting of the Clark County Medical Society was held on Nov. 3 at the Ker-Deen Inn. Dr. M. D. Prugh, Dayton, Councilor of the Second District of the Ohio State Medical Association, presented 50-Year Awards to Dr. D. W. Hogue, Dr. J. A. Link, Dr. C. W. Evans and Dr. R. C. Hebble.

MIAMI

A team from the Ohio State University College of Medicine, Columbus, presented a symposium on the subject, "The Pre-Malignant and Malignant Lesions of the Skin and Mucous Membranes," at the Nov. 4 meeting of the Miami County Medical Society in Piqua. The team consisted of Dr. E. B. Heisel, Dr. Arthur G. James, and Dr. Hans G. Schlumberger. The Society previously endorsed the proposed $100,000 bond issue for the construction at the Dettmer Hospital of a health unit which will aid in unifying the county health departments. The Society's new radio program on Station WPTW at Piqua is entitled "Music With Your Meals," and is heard at 10:30 a. m. Saturday mornings. It was announced that the Society was the first with a membership of over 40 in the State to whose members had contributed 100 per cent to the A. M. A. Assessment. (Editor's Note—According to records in the O. S. M. A. Headquarters Office at the time of this writing, only two other county societies can claim 100 per cent contributions. They are the Carroll and Noble County Medical Societies with memberships of nine and four, respectively.)

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

WYANDOT

Dr. C. Craig Bowman, Upper Sandusky, Councilor of the Third District of the Ohio State Medical Association, presented 50-Year Pins and Certificates to Dr. Alfred W. Balsley, Carey, and Dr. L. W. Naus, Upper Sandusky, at a



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Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

PUTNAM

Dr. C. J. Ray of Gilboa was presented the 50-Year Pin and Certificate of the Ohio State Medical Association at the Nov. 1 meeting of the Putnam County Medical Society in Columbus Grove. Dr. Carll S. Mundy, Toledo, Councilor of the Fourth District of the Association, made the presentation and discussed the subject of prepaid medical and hospital insurance. Dr. H. A. Neiswander spoke in behalf of Dr. Ray's long service as a physician.

The following officers were elected for the coming year: Dr. M. W. Palestrant, Continental, president; Dr. Donald B. Lucas, Columbus Grove, vice-president; and Dr. Carl J. Heitz, Fort Jennings, secretary-treasurer.

SANDUSKY

Dr. H. K. Shumaker, Bellevue, and Dr. E. W. Baker, Fremont, were presented the Ohio State Medical Association's 50-Year pins and certificates when the Sandusky County Medical Society met in Clyde. The presentations were made by Dr. Carll S. Mundy, Toledo, Councilor for the Fourth District of the Association. The scientific program consisted of a discussion by Dr. Henry A. Zimmerman, Cleveland, on the subject of congenital heart disease.

WOOD

The Wood County Medical Society resumed its regular dinner meetings after the summer vacation at Don's Point restaurant, Perrysburg, on Oct. 21, with Dr. Paul Orr, presiding.

At the business session a resolution was adopted opposing the socialized medicine program before Congress. Arrangements were made to have 50-Year Pins and Certificates presented at the November meeting. The scientific program consisted of a Symposium on Poliomyelitis by Dr. Lawrence I. Clark and Dr. Albert L. Bershon of Toledo.

Dr. Clark discussed the etiology and acute phases of polio with the work of the Roosevelt Foundation. His talk on the relationship of polio to pregnancy was interesting as was his presentation of the problem of infection in the higher age groups.

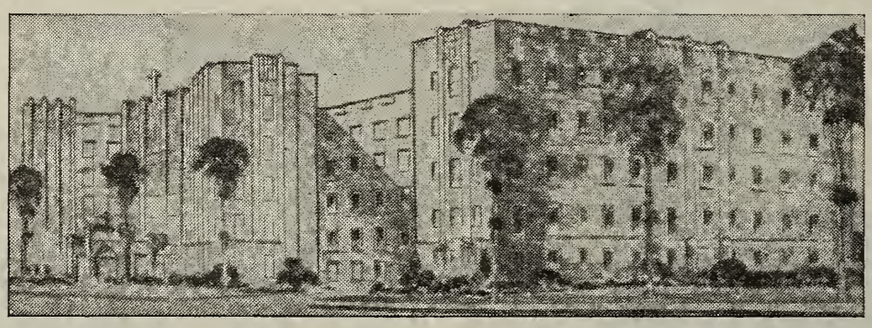
Dr. Bershon dwelt on the later stages and the orthopedic sequelae. He stressed the necessity of bed rest and the avoidance of fatigue, the differential diagnosis of muscle spasm and the importance of watching for deformities. He mentioned use of tolserol and the desirability of psychiatric consultation. An extensive question period followed the discussions.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

CUYAHOGA

Obstetrical and Gynecological Section, Oct. 25—A symposium on "Para-Partum Psychoses" included a discussion on etiology, types and prophylaxis by Dr. Victor M. Victoroff and a discussion of treatment by Dr. Joseph L. Fetterman.



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Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

MAHONING

The Mahoning County Medical Society and the Corydon Palmer Dental Society met jointly on Oct. 18 for the first time since the war, before which it was an annual affair. Speaker for the occasion was Dr. Donald Kerr, University of Michigan School of Dentistry.

PORTAGE

"Bronchial Infections" was the topic of a discussion by Dr. Earle B. Kay of Cleveland before the Nov. 3 meeting of the Portage County Medical Society.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

Senator Robert A. Taft discussed the medical-government relationship at the Oct. 20 meeting of the Belmont County Medical Society. A scientific discussion was given on the subject, "Surgery in Children" by Dr. Gilman D. Kirk, Columbus, Ohio State University College of Medicine. Approximately 200 persons attended the meeting, including druggists, dentists, lawyers and clergymen.

TUSCARAWAS

At the Oct. 20 meeting of the Tuscarawas County Medical Society Dr. James M. Muckley, staff member of Aultman Hospital, Canton, gave an address on "Pneumarthrography."

Eighth District

(COUNCILOR: CHESTER P. SWETT, M. D., LANCASTER)

GUERNSEY

The Oct. 20 meeting of the Guernsey County Medical Society was held at the Hotel Berwick with Dr. William Denny presiding. Arrangements were made for presentation of the 50-Year Pin and Certificate to Dr. W. G. Lane, Cambridge, at the Nov. 9 meeting of the Rotary Club by Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Ohio State Medical Association. The Society was informed that plans for merging the Cambridge City and Guernsey County Health Departments had been completed and would be effected the first of the year. A committee was appointed to contact members who had not paid the A. M. A. assessment. The scientific program was in charge of Dr. Reo Swan who showed film on the subject, "Congenital Cardiovascular Anomalies Amenable to Surgery."

At the Nov. 3 meeting of the Society it was agreed that contributions to the Community Chest would be on an individual basis. The ap-

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plication of Dr. Robert Crouch was presented and he was received as a member. Dr. M. S. Lawrence, Quaker City, was in charge of the program. He presented Mr. William Taylor and Dr. J. A. Arcellana of A. L. Brown Laboratory, Columbus, who showed a motion picture on "The Papanicolaou Technique in Early Diagnosis of Cancer."

LICKING

Three Licking County physicians were presented 50-year pins and certificates in the name of the Ohio State Medical Association at the meeting of the Licking County Medical Society on Nov. 3. They are Dr. George W. Burner, Johnstown; Dr. Joseph W. Barker, Newark; and Dr. George N. Brown of Hebron. Dr. Chester P. Swett, Lancaster, Councilor of the Eighth District of the Association made the presentations. Members of the Society were guests of the personnel department and management of the Owens-Corning Fiberglas Corporation.

MUSKINGUM

At the Sept. 14 meeting of the Muskingum Academy of Medicine, Dr. Paul J. Fuzy of Youngstown spoke on the subject, "Diagnostic Proctology in General Medicine."

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

LAWRENCE

In cooperation with National Diabetic Week, Oct. 10-16, members of the Lawrence County Medical Society made free urinalysis at their offices for all persons requesting them during that week.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FRANKLIN

"Office Management of Syphilis" was the subject discussed by Dr. Loren W. Shaffer, Detroit, Mich., at the Oct. 17 meeting of the Columbus Academy of Medicine.

ROSS

Dr. Gilman D. Kirk, Columbus, discussed the subject, "Socialized Medicine," at the Nov. 3 meeting of the Ross County Medical Society.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

RICHLAND

Dr. W. H. McGaw of Cleveland was speaker for the meeting of the Richland County Medical Society on Oct. 20. His subject was, "A Discussion of Problems in the Treatment of Fractures." The dinner meeting was held at the Mansfield General Hospital.

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TENTH DISTRICT MEETING

The Fort Hayes Hotel was the scene on Oct. 17 of the third annual meeting of the Tenth District. Following the luncheon, the message of welcome was given by Mrs. Oscar W. Jepsen, president of the Franklin County Auxiliary. Mrs. C. W. Kirkland, state president, was one of the honored guests and gave some highlights of her experiences at the other district conferences. She closed her remarks with these pertinent words: "We are dedicating this year to the 'Cause of Liberty'." Mrs. George Cooperrider, state president-elect, spoke briefly and announced that eight new counties had been organized in the state.

Speaker of the afternoon, introduced by Mrs. Richard Carlisle, was Mrs. Elizabeth P. August, secretary of the Ohio State Nurses' Association. She offered her services and that of her other state officers in assisting auxiliaries to encourage high school students and junior high students to choose nursing as a career. Mrs. August's talk was followed by a report from each county president or representative.

Mrs. N. M. Reiff, Tenth District director, presided and introduced each speaker with a bit of original verse. She announced that the Tenth District is the only district in the State to be one hundred per cent organized. Mrs. Reiff talked briefly on the obligation of each auxiliary member to do her part in the fight against socialized medicine. The Columbus Auxiliary was hostess to the District. A vote of thanks was given to the local auxiliary committee. Mrs. Emmerich von Haam acted as chairman, assisted by Mrs. Carlisle and Mrs. Roy E. Krigbaum.

ALLEN

Dr. F. D. Rodabaugh gave an illustrated lecture "With an Army Doctor in China" before the members of the Woman's Auxiliary to the Lima and Allen County Academy of Medicine on Oct. 25. Reports of the meetings held at Columbus and at Marion were given by Mrs. W. B. Light, Mrs. H. C. Thomas and Mrs. R. L. Techlenberg.

Following a short business meeting, Mrs. M. M. Sondheimer read the letter "Public Relations Objectiveness." Plans were completed for the annual benefit bridge party held on Nov. 15 at Lima Memorial Hospital. This annual event makes possible the securing of funds for the Student Nurses' Loan Fund. Thirty members were present, with one new member—Mrs. Harry Warshawsky—being introduced.

BELMONT

A joint meeting of the Belmont County Medical Society and its auxiliary was held on Oct. 20 at the Belmont Hills Country Club. Senator Robert Taft was one of two guest speakers; his talk was on socialized medicine. Following Senator Taft's address, the two groups held brief business meetings, adjourning to hear Dr. Gilman Kirk, associate professor of surgery at Ohio State University, speak on "Surgery on Children." Later dinner was served to members and guests.

BUTLER

Mrs. Azel Ames was hostess on Oct. 25 to the Butler County Auxiliary when it met at her home for its regular monthly meeting. Following the business session, Mr. Joseph Lindemann gave an interesting talk on "Antiques as a Hobby." Concluding the afternoon's program, tea was served to members and guests by Mrs. William H. Henry, president of the auxiliary; Mrs. Paul Ivins and Mrs. Ross Hill. Auxiliary members from Hamilton, Middletown, and Monroe were also present.

DELAWARE

The Delaware County Auxiliary, recently organized, met on Oct. 11, with Mrs. E. V. Arnold as hostess. The new constitution and by-laws, drawn up by Mrs. M. S. Cherington and Mrs.



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E. C. Jenkins, were read and adopted. The members were extended an invitation to attend the tenth district meeting. The next meeting was scheduled to be held at the home of Mrs. G. T. Blydenburgh on Nov. 8.

FAIRFIELD

The Auxiliary to the Fairfield County Medical Society held a luncheon meeting on Sept. 12 at Colonial Courts. Mrs. F. W. James presided over a short business meeting, and welcomed Mrs. C. R. Reed as a new member and Mrs. G. F. Jones as a guest. Mrs. Chester P. Swett introduced the guest speaker, Miss Martha Gesling, associate professor of education at Bowling Green University. Miss Gesling spoke on "The Exceptional Child."

The October meeting of the Fairfield Auxiliary was held at the home of Mrs. C. B. Snider. Mrs. F. W. James presided at the business meeting. Various projects of the auxiliary were discussed by the chairman, Mrs. W. D. Nusbaum. On display was a sample of the thermos sets recently purchased by the auxiliary for Lancaster Hospital. During the social session, tea was served, with Mrs. F. A. Dowdy presiding at the tea service. Assistants were Mrs. William Jasper and Mrs. H. W. Taylor.

FRANKLIN

The first meeting of the fall season was held on Sept. 19 at Jeffrey House. The social committee planned a smorgasbord, as the luncheon feature. Mrs. N. M. Reiff, Tenth District director, was guest speaker at the meeting, at which 40 new members were welcomed. Mrs. George H. Bonnell, Jr., was chairman of hostesses, with Mrs. William F. Lovebury as co-chairman.

GREENE

The new Greene County Memorial Hospital, when completed, will be "one of the finest small hospitals in Ohio," Dr. S. C. Ellis told members of the Auxiliary to the Greene County Medical Society, at a luncheon meeting at Trebein Manor on Oct. 5. Dr. Ellis, a member of the hospital's four-man board of trustees, was guest speaker at the meeting which marked the beginning of the auxiliary's second year.

Mrs. H. C. Schick, president, gave the address of welcome and announced committee appointments for the coming year. Plans also were announced for the December meeting, planned as a Christmas party with the husbands of the members as guests. The Greene County auxiliary meets every two months. Officers besides Mrs. Schick are Mrs. Paul D. Espey, president-elect; Mrs. Robert D. Hendrickson, secretary; Mrs. Norman Linton, treasurer; Mrs. H. C. Messenger, immediate past-president.

KNOX

Members of the Auxiliary to the Knox County Medical Society heard Miss Margaret Hunsicker

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of Columbus talk on "Nurse Recruitment" at the October meeting held at the home of Mrs. Julius Shamansky. Miss Hunsicker is associate general secretary of the Ohio State Nurses' Association. Presiding at the brief business session was Mrs. J. L. Baube, president. Mrs. Baube and Mrs. Charles Tramont presided at the serving table.

LUCAS

Dr. Max Schnitker, recently returned from England, spoke on "Nationalized Medical Practice in England" when the Toledo and Lucas County Auxiliary held its first luncheon meeting of the fall season at the Toledo Woman's Club on Oct. 18. Eighty-five members heard the doctor give a most comprehensive review of the medical situation in England today. Mrs. R. E. Sinkey introduced the speaker. Mrs. F. W. Clement presided and welcomed the new members. She announced the appointment of standing committee members.

The Toledo and Lucas County Auxiliary has two study groups which meet monthly: one on "Child Development" and the other on "Live Issues of Today." In addition, it has a Legislative Workshop which meets every two weeks through November and December.

MARION

State and district officers joined auxiliaries of the Third District in Marion on Oct. 22 when the Woman's Auxiliary to the Marion County Academy of Medicine was hostess to the district meeting. Luncheon was followed by the business session and program.

Guests included Mrs. C. W. Kirkland, state president; Mrs. George Cooperrider, state-president-elect; Mrs. Roswell Fidler, state program chairman. Auxiliaries represented were from Allen, Crawford, Wyandotte, Logan, Mercer and Marion Counties.

Mrs. Harold K. Mouser, Third District director, was in charge of the meeting. Greetings were extended by Mrs. Lucretia Taylor, vice-president. Informal talks were given by the state and district officers and plans for the year's activities were discussed. For the program hour, Mrs. John F. Lacey and Mrs. Mouser played a group of two-piano numbers, and Mrs. Clarence W. Weber reviewed "The Plant in My Window." The story centers on a philodendron and to carry out the theme, the luncheon places were marked with favors of philodendron plants in tinsel wrapped holders.

Arrangements were in charge of a committee composed of Mrs. Clare Smith, social chairman; Mrs. Floyd Yeager, Mrs. M. M. Weinbaum and Mrs. Robert Logsdon. This meeting took the place of the first regular meeting of the Marion Auxiliary. Officers of the Marion group are: Mrs. Frederick T. Merchant, president; Mrs. James S. Greetham, president-elect; Mrs. Taylor,



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vice-president; Mrs. Samuel Katz, recording secretary; Mrs. Merritt Marshall, corresponding secretary; Mrs. N. Sifritt, treasurer.

MERCER

Mrs. R. G. Schmidt and Mrs. R. J. Beare were hostesses at a luncheon on Oct. 18 at the Beare home for the newly organized auxiliary to the Mercer County Medical Society. Mrs. George Cooperrider, state president-elect, was present at this first meeting of the auxiliary following its organization. The officers for the year include: Mrs. W. C. McNeil, president; Mrs. R. G. Schmidt, president-elect; Mrs. L. M. Otis, vice-president; Mrs. E. J. Wilke, secretary; and Mrs. E. J. McLaughlin, treasurer.

Mrs. McNeil presided at the meeting. The third Tuesday of each month was chosen as the meeting date. The chief project for the year, it was decided, will be assistance to the Mercer County Red Cross in any way possible.

MONTGOMERY

The October meeting of the Montgomery County Auxiliary was a benefit card party in the ballroom of the Hotel Biltmore. Following the serving of dessert, 65 tables of bridge or canasta were in play. The proceeds from the card party will be applied to one of the auxiliary's important projects—the student nurses' scholarship fund. Chairman of the card party was Mrs. R. P. Moon.

OTTAWA

The Woman's Auxiliary to the Ottawa County Medical Society met on Oct. 20 at the home of Dr. and Mrs. George Boone. The year's program, as outlined by Mrs. George Poe, program chairman, was presented for the approval of the members. During the evening, the group made 60 Halloween favors to decorate the patients' trays at Magruder Hospital on Halloween. New committee chairmen were appointed. The doctors joined their wives later in the evening and a lunch and social hour followed.

RICHLAND

Dr. Robert Peirce was guest speaker on Nov. 7 when the members of the Richland County Auxiliary met at the Woman's Club for a luncheon meeting. Mrs. Harry Wain and Mrs. Lewis Smith were hostesses.

There were 37 members present to hear Dr. Peirce discuss "Psychoneurosis." Mrs. F. J. Heringhaus, president, conducted the business meeting. Mrs. Russell Barnes reported on her contact with the County Home. Three new members were welcomed into the auxiliary.

SANDUSKY

The Sandusky County Auxiliary held its first fall meeting at the home of Mrs. Robert Fox. Activities for the year were discussed. Mr. Harry Hefner of Detroit will be the guest speaker on Nov. 29 when the auxiliary will meet

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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 20. Vaginal Approach to Pelvic Surgery, one week, starting March 6.

OBSTETRICS—Intensive Course, two weeks, starting March 6.

PEDIATRICS—Intensive Course, two weeks, starting April 3.

MEDICINE—Intensive General Course, two weeks, starting April 24. Gastroscopy, two weeks, starting March 6.

DERMATOLOGY—Formal Course, two weeks, starting May 8. Informal Clinical Course every two weeks.

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at the Nurses' Home to hear his talk on socialized medicine. The public will also be invited.

This first meeting, described as a special party, was a tribute to Mrs. Malcolm Riddell, past-president. A buffet lunch was served and presiding at the tea table were Mrs. Riddell and Mrs. A. F. Schultz. A social hour followed.

STARK

A review of the book, "Human Destiny," highlighted the Oct. 11 meeting of the Stark County Auxiliary held at the residence of Mrs. L. L. Lawrence. Mrs. Mark Herbst presided at the business meeting when several reports were presented. Mrs. I. B. Hamilton, membership chairman, introduced 10 new members.

Mrs. A. A. Fisher, public relations chairman, told of the group's work at the medical society county fair booth and the distribution of posters for the current diabetic campaign. She introduced Mrs. Bernard Donnelly of the Stark County Welfare Federation who told of the work with the aged under the Golden Age club project. The auxiliary will sponsor the recreational programs for one of the groups for a six-month period. Reports on *Hygeia*, and the annual benefit dance to be held in January were also made. Mrs. O. R. Clovis was appointed chairman of the constitution revision committee.

OFFICERS' CONFERENCE

The luncheon and conference of Presidents and Presidents-Elect with the Auxiliary Board was held in Columbus on Oct. 19 at the Fort Hayes Hotel. The Auxiliary Board meeting was held prior to the luncheon and conference with the local auxiliary officers. Mrs. C. W. Kirkland presided at this business session of the Board. Minutes of the last meeting, treasurer's report, and the reports of committee chairmen were given.

Guest speakers at the luncheon included Dr. H. M. Clodfelter, Councilor of the Tenth District of the Ohio State Medical Association, and chairman of the Advisory Committee of the Woman's Auxiliary; Dr. Carll S. Mundy, Councilor of the Fourth District, and chairman, Committee on Rural Health, and Mr. George H. Saville, director of the Department of Public Relations of the Association.

Dr. Clodfelter's remarks had to do with the recent action of the Government in charging medical societies with alleged violation of the anti-trust laws. "We feel that one of our government agencies is using another branch of the government to discredit organized medicine," he said. Dr. Mundy's talk was on rural health and what is being done in Ohio to assist the program of rural health. Said Dr. Mundy: "I

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believe it is one of the most important activities organized medicine is engaged in at this time." And then he added, "There is much that can be done, without resorting to any revolutionary change."

Mr. Saville explained to the auxiliary members what the Ohio State Medical Association is doing for the public. He pointed out that "every activity is either directly or indirectly for the public interest." He then told something of the various activities that include such important projects as the Ohio Medical Indemnity Service, the Committee on Education, the Speakers' Bureau, the Committee on Scientific Work, the Committee on Cancer, the Committee on Medical Care of Veterans, School Health, Public Relations, the Association's Placement Bureau, Health Education and Exhibits, and so on.

Following these addresses, the meeting was turned over by Mrs. Kirkland to the President-Elect, Mrs. George Cooperrider, who presided at the Conference of Presidents and Presidents-Elect. Each district director present gave a short report, following which she introduced the auxiliary presidents from her district. Each auxiliary president introduced her president-elect, and then briefly summarized the activities of her local group. A question-and-answer period followed.

COMING MEETINGS

Ohio State Medical Association, Annual Meeting, Cleveland, May 16-18, 1950, Cleveland.

American Medical Association, Annual Session, San Francisco, Calif., June 26-30, 1950.

American Medical Asosciation Interim Session, December 6-9, Washington, D. C .

Radiological Society of North America, 35th Annual Meeting, Cleveland, Dec. 4-9.

National Conference on Rural Health, Kansas City, Mo., Feb. 3-4, 1950.



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